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ABSTRACT

"Zero to Three" is a single-focus bulletin of the Zero to Three: National Center for Infants, Toddlers, and Families providing insight from multiple disciplines on the development of infants, toddlers, and their families. Noting that some communities are managing to establish and sustain good-quality infant-toddler care and to make it accessible to families with low incomes, this issue focuses on community partnerships for quality infant-toddler child care, based on a study of such programs by Zero to Three and Mathematica Policy Research. The articles are as follows: (1) "Quality Child Care for Infants and Toddlers from Families with Low Incomes: Lessons Learned from Three Communities" (Diane Paulsell, Renee Nogales, and Julie Cohen); (2) "The Community Consolidated Child Care Pilot Services Program, El Paso County, Colorado" (Paulsell and Nogales); (3) "Kansas and Missouri Early Head Start Programs: Kansas City, Kansas, and Sedalia, Missouri" (Paulsell and Nogales); (4) "Mountain Area Child and Family Centers, Buncombe County, North Carolina" (Paulsell and Nogales); and (5) "Parent Perspectives" (Paulsell and Nogales). Two additional articles not resulting from the study are: "Time To Care: Redesigning Child Care" (Joan Lombardi); "Promoting Mental Health in Child Care Settings: Caring for the Whole Child" (Ray Collins, Janet Mascia, Rosemary Kendall, Oxana Golden, Linda Schock, and Rebecca Parlakian). Regular departments of the bulletin list Zero to Three publications, videotapes and on-line resources, and announcements about Zero to Three staff. (HTH)



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Journal of ZERO TO THREE: National Center for Infants, Toddlers, and Families

Partnerships for Quality Infant-Toddler Child Care

Community Collaborations
in Four States

Parents With Low
Incomes Speak Out
About Quality Care

Seven Principles for
Redesigning Child Care

Promoting Mental Health
in Child Care Settings

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EDITOR'S NOTE

Child care is now a typical, rather than an exceptional experience for America's babies and toddlers. Some see this trend as a risk to healthy development, others as a chance for communities to support both children and families in the earliest years of life.

What seems to make the difference between developmental risk and developmental opportunity in the context of infant-toddler child care is the quality of the child's experience. Child development professionals and parents agree on the elements of good quality—attention to health and safety, engaging and well-equipped caregiving environments, appropriate child-caregiver ratios, and—most important—warm, responsive, stable relationships between children and caregivers.

Quality within a child care setting requires an infrastructure of support beyond it. Child care providers need training opportunities, linked to compensation. Providers and directors need technical assistance as they work to improve the quality of the environment and of caregiving practices. They need expert consultation in order to serve appropriately the full range of infants, toddlers, and families in a community.

Good-quality child care for infants and toddlers is costly. So costly that many potential providers don't serve babies at all. So costly that state child care subsidies seldom if ever cover the cost of good infant-toddler care. As a result, many families with low incomes lack access to one of the supports most likely to increase their infants' and toddlers' chances for healthy development.

Some communities are managing to establish and sustain good-quality infant-toddler care and to make it accessible to families with low incomes. With support from the Child Care Bureau of the US Department of Health and Human Services and the Ewing Marion Kauffman Foundation, ZERO TO THREE and Mathematica Policy Research, Inc. (MPR) studied collaborative community efforts designed to improve access of families with low incomes to good-quality infant-toddler care. The first five articles in this issue of *Zero to Three* report lessons learned from the study as a whole as well as the experiences of partnerships in individual communities and the perspectives of parents. Next, Joan Lombardi calls for a redesign of child care so that it will support the healthy development of infants and families. Learning from the experience of the military child care system, she calls for standards and enforcement, training and compensation, and an infrastructure of support. Finally, staff of the National Child Care Information Center and ZERO TO THREE describe innovative and urgently needed partnerships between child care and mental health providers, programs, and systems.

Generous, trustworthy, and skilled support made possible the work reported in this issue and its dissemination here. ACYF Grant #90YE0023/01 from the Child Care Bureau funded the ZERO TO THREE/MPR study, *Quality Child Care for Infants and Toddlers: Case Studies of Three Community Strategies*. The Child Care Bureau Research Team provided invaluable review, guidance, and encouragement. Support from the Ewing Marion Kauffman Foundation allowed us to examine in-depth the extraordinary partnerships being nurtured in Kansas and Missouri. Ellen Kisker (title) and Erica Lurie-Hurvitz, Director of the ZERO TO THREE Policy Institute, nurtured the ZERO TO THREE/MPR partnership and provided intellectual, practical and policy-relevant leadership to the team's efforts. The Century Foundation supported Joan Lombardi's creation of *Time To Care* and allowed excerpts to appear in this issue. Our deepest appreciation, of course, goes always to the parents, child care professionals, and community partners who have allowed others to witness their struggles and learn from their work on behalf of babies and toddlers.

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Cover photography: Janet Brown McCracken



QUALITY CHILD CARE FOR INFANTS AND TODDLERS FROM FAMILIES WITH LOW INCOMES: *Lessons Learned from Three Communities*



DIANE PAULSELL and RENÉE NOGALES
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In fall 2000, ZERO TO THREE and Mathematica Policy Research, Inc. (MPR), with funding from the Child Care Bureau of the U.S. Department of Health and Human Services, began a 2-year study of collaborative community efforts designed to improve access of families with low incomes to good-quality infant-toddler care. Nationwide, the search for good-quality child care for very young children is a source of stress for almost all working families, but especially so for families of limited means. Caregiving arrangements for infants and toddlers have changed dramatically over the last 20 years as more and more parents—either by choice or by necessity—have returned to work shortly after the birth of a child. Currently, almost half of all babies under the age of 1, more than half of all 1-year-olds, almost 60% of all 2-year-olds, and more than 70% of all 3-year-olds spend the day in child care (1999 National Household Education Survey, as cited in Shonkoff & Phillips, p. 298). Some of these young children are in high-quality care that their parents searched for or happened upon, that had an opening when they needed it, and that their parents could afford. Many other infants and toddlers are cared for in settings that their parents consider simply “all right” and that child care experts would rate as mediocre. Still other families feel lukewarm, at best, about their child care arrangements but have no other choices available and little flexibility about the timing of their return to work or their work schedules.

The ZERO TO THREE/MPR team focused on collaborative community efforts to assist low-income families with infants and toddlers because earlier research led us to believe that it takes intensive, sustained collaboration at the community level to overcome the barriers that confront such families when they try to secure good-quality child care for their infants and toddlers. A review of the literature; telephone interviews with national, state, and local infant-toddler child care experts; and focus groups with front-line child care and Early Head Start staff members confirmed and expanded our awareness of the obstacles families face, particularly in the era of welfare reform. Yet the research literature and our first-year inquiries also suggested that some communities have created effective, enduring systems to increase access for families with low incomes to good-quality infant-toddler care. We formulated three primary research questions:

- What strategies at the community level improve the quality of infant-toddler child care available to families with low incomes?
- What programs and bodies need to collaborate to address issues related to quality of care? How long does it take to form these partnerships?
- What strategies effectively help families with low incomes pay for good-quality child care?



PHOTO: JANET BROWN MCCrackEN

In Year One of the study, the team identified a number of strategies that communities are using—often in the context of Early Head Start–child care partnerships—to improve access of families with low incomes to good-quality care. These strategies include using the flexibility given to states in spending Child Care Development Fund (CCDF) funds and setting income eligibility requirements, fee schedules for parent copayments, and provider reimbursement rates; creating statewide plans for coordinating early childhood services at the local level; developing state- and community-level strategies to increase the supply and improve the quality of care; and establishing public–private partnerships to finance quality child care services. The Year Two case studies allowed the team to see how these

strategies operated in practice, in diverse communities. We selected the participating sites on the basis of specific characteristics (see sidebar p.6). The team looked for initiatives that were well implemented, included a quality component, and involved a broad range of partners. We also wanted sites that, as a group, would include both rural and urban communities, and jurisdictions operating under a variety of child care subsidy policies. The case study communities we ultimately selected were:

- Community Consolidated Child Care Pilot Services Program in El Paso County, Colorado;
- the state-sponsored Early Head Start programs in Kansas City, Kansas, and Sedalia, Missouri; and
- the Mountain Area Child and Family Centers in Buncombe County, North Carolina.

at a glance

- ZERO TO THREE and Mathematica Policy Research, Inc. (MPR) studied community efforts to improve access of families with low incomes to good-quality infant-toddler child care.
- State child care subsidies do not cover the cost of good-quality infant-toddler care.
- Successful communities blend multiple funding streams.
- In case study sites, improving quality involved sustained and intensive technical assistance to child care providers.
- Investments in provider training and compensation improved quality.
- Aligning federal and state program standards and requirements can enhance community collaboration.

The team developed case studies from information gathered during an intensive 3-day site visit to each community. Each visit included classroom observations and interviews with administrators, program leaders, staff, and parents.

The linked issues of funding and quality in infant-toddler child care—the basis for the team's research questions—turned out to be on the minds of all stakeholders in every case study community. The issues came up again and again in interviews with administrators, program leaders, and front-line staff, and in parent focus groups. Today's volatile economy and policy environment—in the wake of welfare reform, and with both federal and state leaders facing tight budgetary constraints—make the goal of increasing access to



quality infant-toddler care while controlling costs a greater challenge than ever before. The specific, practical lessons learned from the ZERO TO THREE/MPR cross-site analysis of community infant-toddler child care partnerships may help communities across the country in their own efforts to address funding and quality of care.

Funding Good-Quality Infant-Toddler Child Care

Providing infant-toddler care is expensive, in large part because providing the intensive care and supervision that infants and toddlers need requires lower child-caregiver ratios than are needed for older children. Staff members need training in infant-toddler care and development to ensure

that their practices and expectations are age-appropriate and promote healthy development. Infant-toddler child care providers also need adequate space for crawlers and walkers, as well as special equipment such as cribs, high chairs, strollers, developmentally appropriate toys, and age-appropriate outdoor play equipment. Consequently, the fees charged for good-quality infant-toddler care were beyond the means of families with low incomes in the communities studied. Identifying funding sources to pay for good-quality infant-toddler child care thus emerged as a central activity for each of these community initiatives.

In three of the four case study sites, state child care subsidies were accessible to families with low incomes, but subsidy funds alone were not sufficient to cover the cost of care.

CASE STUDY SITE SELECTION CRITERIA: CHARACTERISTICS OF INFANT-TODDLER CHILD CARE INITIATIVES

Criteria	Description
Sufficient experience	Implementation should be far enough along to provide useful operational lessons. As a guide, we will identify initiatives that have been operating for at least 2 years.
Commitment to quality	Initiatives should incorporate a commitment to improving the quality of infant-toddler child care. Specifically, initiatives should support child care providers in maintaining low child-teacher ratios and group sizes, work to increase teacher qualifications and provide training, and promote continuity of care for children over time.
Promising strategies	The initiative should have implemented strategies that appear promising, judging by information collected during preliminary telephone interviews and recommendations from government officials and other child care experts.
Involvement of multiple partners	Because this study seeks to learn about the processes of collaboration, initiatives should involve multiple organizations or service providers and should be linked with other community child care initiatives.
Extent of Early Head Start involvement	Early Head Start is involved in infant-toddler child care initiatives in many communities. However, to ensure inclusion of the non-Early Head Start infant-toddler child care community in the study, at least one key initiative should not include Early Head Start as a central partner.
Types of providers	Initiatives should consist of those who work with child care centers and family child care homes, either regulated or unregulated.
Types of partnerships	At least one comprehensive and one subsidy enhancement partnership (as defined in Year One of the study) should be among the key initiatives studied. ^a
Linkages with other initiatives	The group of initiatives studied across the case study sites should include or have links to the main types of infant-toddler child care initiatives identified in Year One: CCDF-funded initiatives, local planning strategies, initiatives to increase supply, initiatives to improve quality, Early Head Start-child care partnerships, and public-private partnerships.

^aIn Year One of the study, we defined *comprehensive partnerships* as those that formally contracted with providers for child care slots, paid for the full cost of care, and maintained continuity of care. We defined *subsidy enhancement partnerships* as those that contracted for child care slots and provided funds to supplement state child care subsidies obtained for those children. For more details, see *Quality Child Care for Infants and Toddlers: Case Studies of Three Community Strategies* (Paulsell, Nogales, & Cohen, in press).

Parents described searching for infant-toddler providers who would accept the state subsidy; and most reported either that providers in the community would not accept subsidies or that the quality of care their children received from providers willing to accept the subsidy was inadequate. In the fourth community, a long waiting list precluded most families from obtaining a subsidy unless their child had special needs.

Child care providers also cited the challenge of funding infant-toddler child care with state subsidy payments. In Colorado Springs, the city's largest nonprofit child care provider described the difficult decision to close its last infant room, as covering the cost of infant-toddler care had depleted the organization's reserve fund. In North Carolina, staff and board members of the Mountain Area Child and Family Center reported that even the fees charged to families with higher incomes did not cover the true cost of providing infant-toddler care, and state subsidy reimbursement rates were well below tuition rates for paying families.

When providers were not able to cover their costs with state subsidies, they reduced or eliminated infant-toddler slots. Consequently, in all the communities studied, the supply of infant-toddler care was inadequate to meet the demand for regulated care. This section presents the lessons learned from the four community initiatives on how best to fund a stable supply of good-quality infant-toddler care.

- **Child care providers in the case study sites said they must combine multiple funding streams to cover the cost of offering good-quality infant-toddler care for low-income families.**

Although each community took a different approach to blending funding streams to pay for infant-toddler care, key stakeholders in each community emphasized the necessity of combining funds. In Colorado Springs, child care providers formed partnerships with Early Head Start to help pay for child care. For example, a school district operating an on-site child care center at an alternative high school reported that without the Early Head Start partnership, the district could not afford to continue operating its infant-toddler rooms. The district also relied on state subsidies and a variety of other funding sources to pay for the care. In addition, the county welfare office in Colorado Springs supported providers' efforts to open infant-toddler rooms by providing guaranteed funding for these slots during an initial start-up period. In North Carolina, the Mountain Area Child and Family Center raised funds from foundations and private donors to supplement parent fees and state subsidies.

In Kansas and Missouri, Early Head Start-child care partnerships were funded primarily by state-sponsored Early Head Start initiatives. While these initiatives did not combine multiple funding sources (because families enrolled in these programs already received state funding for child care under Early Head Start, they could not access state subsidies), they did provide child care funding that exceeded the levels available through the state subsidy program. In addition to paying providers at rates that were higher than subsidy reimbursement rates, the initiatives paid for equipment and extensive training of staff.

All the case study initiatives further stretched the funds they had by taking advantage of other child care initiatives in their communities. For example, some providers participated in grant programs to purchase equipment; some accessed

wage or health insurance supplement programs. Many took advantage of free or low-cost training opportunities or scholarships provided through state Teacher Education and Compensation Helps (TEACH™) initiatives.

- **When assured of a steady cash flow and ongoing support, family child care providers in the case study sites proved to be a significant source of quality infant-toddler slots for families with low incomes.**

With the exception of North Carolina (where the team studied a child care center), family child care providers participated in the case study initiatives. Key stakeholders in each of these sites reported that family child care homes provided an important source of good-quality infant toddler slots for families with low incomes. Initiatives were particularly successful in identifying and involving family child care providers in neighborhoods where families needed care and center-based infant-toddler slots were not available.

Stakeholders in the case study communities identified two kinds of support that were important to sustaining the involvement of family child care providers. First, because they care for small numbers of children, family child care providers need a steady flow of cash. In Colorado, stakeholders reported that, because of the lag time between the provision of services and receipt of reimbursement, family child care providers often were reluctant to accept state child care subsidies. To remedy this problem, the child care pilot established the Home Network, which reimburses providers weekly. Early Head Start programs also provide prompt reimbursement to family child care providers.

Second, family child care providers were willing to work on quality improvement, but they needed ongoing

State child care subsidy funds alone do not cover the cost of good-quality infant-toddler care. Child care providers combine multiple funding streams in order to offer good care to families with low incomes.

support. In El Paso County, through the Home Network and partnerships with Early Head Start, family child care providers received frequent technical assistance visits, including help with room arrangement, activity planning, communication with parents, and the business aspects of operating a family child care home. In some cases, providers also received equipment such as cribs, shelving, cubbies, and outdoor play equipment, in addition to opportunities to network with other home-based providers.

- Some regulatory barriers that deter child care providers from creating infant-toddler slots in existing facilities can be overcome without putting children's health and safety at risk.

Regulatory requirements for infant-toddler child care are designed to safeguard the health of this vulnerable population. While stakeholders in the initiatives we studied agreed that these safeguards are essential, in some circumstances the safeguards could prevent potential expansion of infant-toddler slots in existing facilities. Especially in Colorado, providers were able to obtain waivers of some requirements by proposing alternative safeguards to protect the children. These waivers enabled providers to increase the number of infant-toddler slots available by using existing facilities; if the waivers had not been granted, the cost of extensive construction or renovation would likely have prevented providers from opening these slots.

- Because funding good-quality infant-toddler slots requires the blending of funding and coordinating programs, building collaboration and partnerships was essential in all the case study sites.

Stakeholders stressed the importance of building strong collaborative relationships with community partners to ensure effective communication and sharing of resources. They also emphasized the importance of sustained leadership by a core group of committed stakeholders to building and sustaining local initiatives. Continuity among these core participants enabled the group to build trust and thus establish a history of positive working relationships that they could draw on during difficult growth phases of the initiatives. In addition, frequent, effective communication at all levels—among key stakeholders at the local and state levels; among providers, funding agencies, and technical assistance providers; and between providers and parents—was essential to forming partnerships and blended funding arrangements. In some communities, strong support from local government agencies, especially the welfare and child care administrators, has been essential to building local

support, working out administrative barriers, and bridging temporary gaps in funding.

- To fund the initiatives, new sources need to be cultivated, which can be accomplished through community outreach and education.

Key informants in all the case study sites felt strongly that community education about the importance of high-quality child care for the healthy development of infants and toddlers has yielded increased support and investment in child care in their communities. The North Carolina initiative, in particular, has been successful in identifying new funders through a vigorous outreach and education campaign.

Improving The Quality Of Infant-Toddler Care

Key stakeholders in the case study initiatives recognize the positive role that good-quality child care can play in the development of infants and toddlers; all of the profiled initiatives emphasized the importance of improving the quality of infant-toddler child care in their communities. While increasing the supply of infant-toddler slots was an urgent need in these communities, most stakeholders felt strongly that initiatives should focus on developing good-quality slots rather than a larger number of slots that met minimal quality standards. As described below, all the initiatives have invested significant resources and staff time in their quality-improvement efforts.

- Improving quality in the case study sites required offering sustained and intensive support to child care providers.

Staff and organizations providing technical assistance through the case study initiatives emphasized the need for intensive support for child care providers. Most of the initiatives included regular visits (ranging from weekly to monthly) to family child care homes or infant-toddler classrooms in centers. During these visits, technical assistance staff checked on how the provider was doing, modeled developmentally appropriate caregiving, and provided guidance on implementing specific activities or curricula. When an initiative included Early Head Start-child care partnerships, technical assistance staff supported providers in implementing the Head Start performance standards.

- Stakeholders also stressed that making the changes necessary for improving the quality of infant-toddler care could best be done incrementally, over time.

Most community stakeholders want to develop good-quality infant-toddler care rather than expand the supply of "slots" of minimal quality.

Technical assistance staff emphasized that providing infant-toddler care is hard work and compensation is often low. Providers often became overwhelmed and discouraged if too many changes were expected at once. Instead, providers needed encouragement, positive reinforcement, and reassurance that changes could be made gradually over time. In most of the initiatives, technical assistance staff said that ensuring adherence to health and safety standards was their highest priority. After health and safety, most focused initially on improving the caregiving environment by purchasing equipment and toys and working with providers on room arrangement. Improving the quality of interactions between caregivers and children, however, usually happened more gradually.

- Improving quality in the case study sites also required significant investments in provider training, provider compensation, and materials and equipment.

In addition to regular technical assistance visits, all the initiatives supported child care providers in obtaining a Child Development Associate (CDA) credential or a higher degree in early childhood education. Early Head Start programs usually paid for this training, or provided it directly to their partner providers. Other initiatives offered free training or helped providers obtain scholarships. In addition, initiatives offered additional training in infant-toddler care and development and on a range of broader child care topics. Some initiatives incorporated bonuses or wage supplements to serve as incentives for providers to obtain training. For example, a wage supplement pilot project in Kansas City, Kansas, offered higher wages to caregivers who obtained additional education. Similarly, the alternative licensing model implemented in Colorado Springs and the star rating system in North Carolina provided substantial financial incentives for meeting higher quality standards. Finally, most of the community initiatives examined here invested in providing developmentally appropriate equipment and toys to child care providers. Early Head Start programs paid for setting up outdoor play areas at family child care homes and purchased cribs, rockers, and other needed equipment.

- With adequate support, child care providers were able to accept and care for children with special needs.

While inadequate supply of infant-toddler care was a significant barrier in the case study communities, finding care for infants and toddlers with special needs was an even bigger challenge. All the initiatives supported child care providers in caring for special needs children by fostering close working relationships with early intervention programs.

All community initiatives studied supported child care providers in obtaining a Child Development Associate (CDA) credential or a higher degree in early childhood education.

Typically, early intervention providers worked with children in the classroom, offered technical assistance to caregivers in how to meet a child's needs, and coordinated with caregivers and parents to establish goals for the child in their child care setting. In Colorado, the child care pilot even established a program to support child care providers in caring for children with significant behavioral problems.

Although providing good-quality infant-toddler care is expensive and challenging, many child care providers in the case study sites were willing to add services for infants and toddlers or to expand the number of slots they offered once they were assured of sustained funding, technical assistance, and support. Thus, each of the case study communities was able to make progress in increasing the number of good-quality infant-toddler slots in its community, especially slots that were accessible to families with low incomes.

Although the sites used a variety of strategies and their community contexts differed, all the case study initiatives made progress by pooling resources, coordinating services, and maintaining close communication among key stakeholders.

Opportunities for Federal and State Governments

Although the community initiatives studied here achieved notable successes in increasing supply and improving quality of infant-toddler care, the dual issues of supply and quality remained a challenge in these communities. In each site, participants in the initiatives hoped to continue expanding services for this age group by increasing the breadth of community collaboration and by seeking additional funding sources. The policy recommendations below describe ways in which federal and state governments, even without additional resources, can support communities in their efforts to collaborate, develop partnerships, and blend funding.

- Increase coordination at the federal and state levels to align program standards and requirements for infant-toddler child care services.

Coordinating rules and procedures across programs and funding streams can help support partnerships by reducing the number of requirements and rules that must be met. For example, aligning quality standards and regulations across initiatives could help underscore the importance of meeting these standards and eliminate confusion at the local level about which set of requirements to follow.

- Coordinate and streamline recordkeeping and reporting requirements to ease the paperwork burden associated with combining funding streams.

When service providers blend funding streams—such as state child care subsidies, public school funds, state funds, or Early Head Start funds—they must adhere to the record-keeping and reporting requirements of several funding sources. Simplifying and aligning financial management requirements would reduce paperwork and avoid duplication of effort in reporting to each funding source.

- Align eligibility periods and requirements for state child care subsidy and other programs to promote continuity of care for children and ensure stable funding sources for child care initiatives.

When eligibility periods and requirements differ substantially across programs, families can lose eligibility for a portion of their funding, thus jeopardizing continuity of care for the child and stable funding for the provider. Aligning eligibility across programs, such as state child care subsidies and Early Head Start, can eliminate this potential source of instability for families and providers.

- Provide a full-day child care subsidy or pay for guaranteed slots in programs that cover a portion of the cost of care. This helps to make manageable the high cost of providing good-quality infant-toddler care.

Some states provide only a partial-day subsidy for children when Early Head Start or other grant funds pay for part of the cost of child care. In these situations, child care subsidy funds frequently are used to pay for "wraparound" child care services, which often are of lower quality because the subsidy is insufficient to pay for good-quality services. In other communities, however, families remain eligible for a full-day subsidy that can be combined with other funding sources to pay for higher-quality care. Similarly, in some communities child care subsidy funds can be used to purchase guaranteed child care slots. This arrangement guarantees funds for infant-toddler slots, regardless of whether a child is out sick or a family loses eligibility for the subsidy, thus increasing the stability of funding for the provider.

Conclusion

Profiled initiatives have found that meeting the dual challenge of providing both more infant-toddler child care slots and higher-quality care requires, first and foremost, close collaboration across all levels of the program and community, the municipality, and the state. In the profiled sites, collaborative work across these stakeholders supported the pooling of resources, the provision of consistent and sustained support to providers, and the coordination of regulations, records, and services—all of which were cru-

cial elements necessary to meeting the goals of more openings and higher quality care.

Ultimately, communities began to see their efforts rewarded as providers made incremental—but positive—changes in both the quality of care and the number of infant-toddler openings. Most important, providers passed the real test—that of parents and children. Said one parent:

"I wish everyone had a place like this where they could take their children. It's just a big relief to know...that I can go to work and focus on my work. And...know that he is having a blast here" (Paulsell, Nogales, & Cohen, in press). Child care providers such as these support not only the parent and child, but the entire community. ♣

Meeting the dual challenge of providing both more infant-toddler child care and higher-quality care for children from families with low incomes requires close collaboration among program, community, municipality, and the state.

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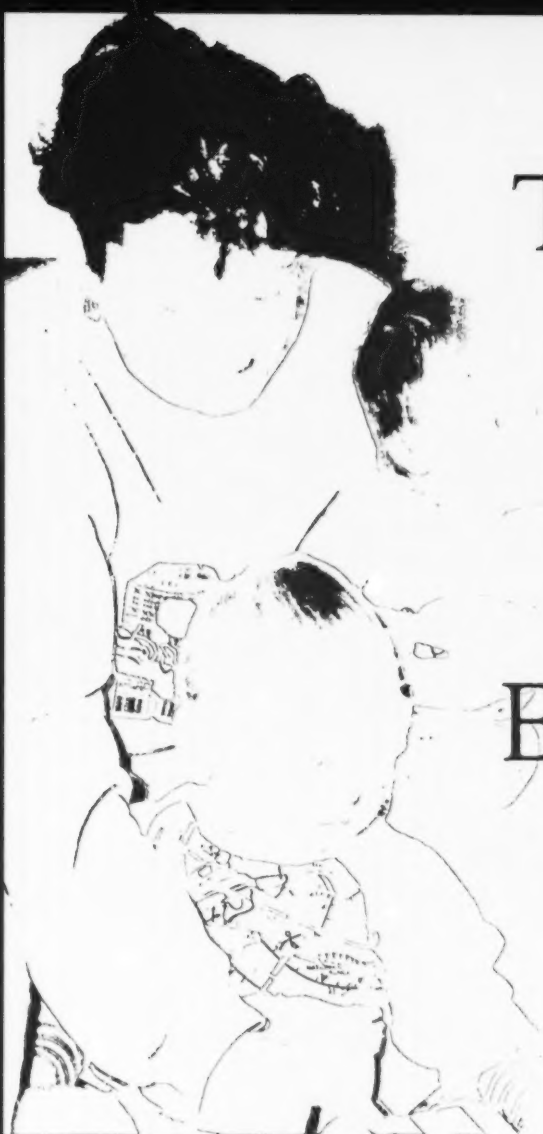


PHOTO: JANET BROWN MCCrackEN

THE COMMUNITY CONSOLIDATED CHILD CARE PILOT SERVICES PROGRAM, EL PASO COUNTY, COLORADO

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The Community Consolidated Child Care Pilot Services Program in El Paso County, Colorado, is designed to create a seamless system of full-day, full-year, high-quality early care and education services for children from families with low incomes. This case study, based primarily on data collected during a site visit in May 2002, describes the development of the county's pilot initiative, introduces the model programs created by the pilot, and highlights lessons learned from El Paso County's experience.

About the Community

El Paso County is one of the fastest-growing regions in Colorado and in the United States; between 1990 and 2000, the population grew approximately 30% (U.S. Census Bureau, 2001). Approximately 39,000 children are under age 5, with 5,580 of those children living in poverty (U.S. Census Bureau, 2001).

Child Care Supply and Demand

Key stakeholders report that the supply of regulated infant-toddler child care slots accessible to families with low incomes falls substantially short of the demand. As in many communities, infant-toddler care is either too expensive or not of good quality, and families with low incomes often do not have adequate choice in child care options for their infants and toddlers.

Child Care Subsidy Program

The El Paso County Department of Human Services (DHS) administers the Colorado Child Care Assistance Program (CCCAP), which provides child care subsidies for families with low incomes. El Paso County has set its eligibility limit for subsidies at 160% of poverty for initial eligibility and 185% for continuing eligibility. Families participating in CCCAP who are not on Transitional Assistance for Needy Families (TANF) and who have incomes at 50% of poverty or higher must make a copayment to contribute a

portion of the cost of care. Approximately 5,500 children receive CCCAP subsidies in any given month. In 2002, El Paso County did not have a waiting list for subsidies.

Child Care Subsidy Reimbursement Rates

Colorado counties conduct market rate surveys at least every other year to help them set reimbursement rates for licensed providers with CCCAP contracts. Exempt providers (unregulated home-based providers, sometimes relatives, who care for the children of only one family) also qualify for CCCAP reimbursement. In El Paso County, the Department of Human Services pays families directly to purchase exempt care. The rate of reimbursement for exempt providers is about one-half the rate for centers.

History of Community Consolidated Child Care Pilot Services Program

In 1997, the Colorado General Assembly created the Community Consolidated Child Care Pilot Services Program to address an anticipated need for child care resulting from welfare reform. The legislation (Colorado Senate Bill SB97-174) directed the Colorado Department of Human Services to designate 12 pilot communities. Each of these communities was charged with developing models for seamless service systems that could provide full-day, full-year early care and education services to children from families with low incomes. Specifically, pilot communities were directed to:

1. combine funding streams (in particular, funds from CCCAP, the Colorado Preschool Program [CPP], and Head Start);
2. increase collaboration among early care and education service providers and other local stakeholders;
3. provide high-quality early care and education services; and
4. design services in response to the needs of working parents with low incomes.

The 1997 legislation also authorized the Department of Human Services to waive any state rule, regulation, or law that impeded the pilot communities from implementing a seamless service system that met the needs of working families with low incomes. In addition, to ensure that the pilot communities had both support from key stakeholders and the flexibility to combine funding streams, the state required communities applying for pilot status to include the superintendents of schools (who administer CPP funds) and the county commissioners (who oversee administration of CCCAP and TANF funds) as pilot partners.

¹In El Paso County, Colorado, CCCAP is funded through a combination of funds from the Child Care and Development Fund (CCDF) and TANF transfers.

El Paso County's Consolidated Child Care Pilot Program

When the child care pilot legislation was passed, El Paso County Department of Human Services (DHS) officials encouraged the local child care community to apply to become one of the 12 pilot communities. The application was successful, and the Alliance for Kids (known as the Alliance) was formed to oversee the child care pilot. By 2002, the Alliance had more than 30 member organizations and one paid staff member, a coordinator.

Development of El Paso County's Child Care Pilot Models

Once El Paso County became a pilot site and the Alliance for Kids was established, the pilot subcommittee began the process of collecting input from stakeholders and developing a strategic plan for creating an early care and education system. One pilot partner said that the program offered the community a chance to develop a "master plan for building quality and full-day, full-year capacity for early childhood care and education" (Paulsell, Nogales, & Cohen, in press.)

El Paso County's initiatives ("pilot models") focused on four key objectives. There were models designed to:

1. increase the number of child care slots available to families with low incomes,
2. increase families' access to a range of child care options,
3. improve child care quality, and
4. support children with special needs in child care.

Following is a description of the pilot models addressing each of these objectives.

Models to Increase the Number of Infant-toddler Slots for Families With Low Incomes

In El Paso County, the high cost of providing infant-toddler care, coupled with low CCCAP reimbursement

at a glance

- The Alliance for Kids in El Paso County, Colorado, is one of 12 communities charged by the state to respond to the child care needs of working families with low incomes.
- Streamlining reimbursements to family child care providers expanded infant-toddler capacity.
- Streamlining application and eligibility redetermination procedures helped parents.
- Training on responsive caregiving is one of several quality improvement initiatives.
- A Child Care Response Team helps parents and providers assist children with behavioral or developmental challenges.

rates and the mandated lower child-caregiver ratios for this age group, means that child care providers cannot cover the cost of infant-toddler care with CCCAP reimbursement alone. The child care pilot sought to eliminate these barriers; ultimately, six pilot models were created to increase infant-toddler capacity (described below). These models generated 130 infant and toddler slots.

Home Network. The Home Network is a family child care model designed to increase choices of child care settings for families with low incomes.

Launched in January 2000, it seeks to increase the availability of slots in family child care homes. Home-based providers noted that the long time it took to receive CCCAP reimbursements for child care services was a deterrent to creating CCCAP slots. In response, the Home Network provides frequent (usually weekly) reimbursement and ongoing technical assistance to a group of 20 family child care providers who agree to obtain CCCAP contracts and maintain a caseload of 50% CCCAP children. Reimbursements are sourced from a pool of CCCAP funds loaned from DHS.

Child Nursery Centers, Inc. (CNC)—Antlers Place. This model was developed because the pilot wanted to open a toddler room in CNC's Antlers Place facility. The available room, however, had two steps at the exit, and thus violated state licensing requirements. The pilot applied for a waiver of this requirement. The waiver was approved, though with the addition of several new safety stipulations (e.g., to practice fire drills more frequently). Families with toddlers in this classroom can pay for care through CCCAP. This model is distinctive in that it underlines how important it is that pilot programs be empowered to resolve issues at the local level. By working creatively, this pilot model was able to meet the goal of creating new infant-toddler slots as well as to continue to safeguard children's health and safety.

CNC—South Chelton. The South Chelton facility had once operated an infant room but closed it in the mid-1990s because of the cost of providing care to this age group. CNC—South Chelton reopened the room in January 2002, with a waiver to serve children ages 6 weeks to 36 months in a single room.¹ To pay for the care, DHS agreed to provide guaranteed CCCAP funding at the full-time rate (\$24 per day) for all slots during the first year of operation.

Tesla Early Care and Education Center. This infant-toddler center, operated by School District 11 since

fall 1999, is housed in the Tesla Education Opportunity Program, an alternative middle and high school. It provides care for up to 26 infants and toddlers whose parents attend the school.

Pike Elementary School. Located within School District 11, the pilot facilitated a partnership between the school district and Goodwill Industries to relocate some of its GED classes to the school and add a family literacy component. School District 11 converted available space at the school into infant-toddler classrooms (with capacity for 18 children) to provide child care while parents attend classes. The key component that allowed this project to proceed was the pilot being granted a waiver to use a leather screen, rather than a wall, to separate the infant and toddler rooms.

Hunt Elementary School.

This school also has a partnership with Goodwill Industries to offer on-site GED classes, infant-toddler child care, and family literacy activities. To fund this model, the pilot obtained a waiver to serve infants and toddlers with CPP funds (monies typically earmarked for preschoolers).

Models to Increase Access to Child Care Options

Although CCCAP has been available to families with low incomes without creating waiting lists, the application and eligibility redetermination processes have posed barriers for families. To address this issue, the pilot subcommittee developed several models (described below) to streamline the application process.

Subsidy Application Process. DHS has simplified the CCCAP application process to make the subsidy as accessible as possible to families. A face-to-face appointment at DHS is no longer required; initial intake, eligibility determination, and notification of eligibility are conducted by Child Care Connections (CCC), the local resource and referral agency. In addition, there are several ways to apply, including by mail. The process is now shorter, taking about 4 to 6 weeks, and payments are retroactive to the date of the application.

CCCAP Eligibility for Head Start/Early Head Start Children. Families who are eligible for Head Start and Early Head Start are considered income-eligible for CCCAP. To reduce the number of applications that families must complete, DHS now accepts the Head Start application in lieu of a CCCAP application. In addition, Head Start families' eligibility redetermination is conducted annually for both programs.

Parents can apply for child care subsidies at their local resource and referral agency or by mail. An Early Head Start application can be accepted instead of a subsidy application.

¹According to Colorado's licensing requirements, the upper limit age for children in an infant room is 18 months.

Resource and Referral Services. Resource and referral services are available both by telephone and in person at two sites. Information on vacancies is updated every 6 weeks, enabling CCC staff to provide "hot referrals" that increase families' chances of securing an open slot.

Models to Improve the Quality of Care

A major goal of the child care pilot in El Paso County has been quality improvement. The pilot has sought to implement initiatives that offer support, technical assistance, training, and resources to child care providers who are interested in improving the quality of their child care settings.

El Paso County Licensing Model. In 2000, the El Paso County pilot partners rewrote the child care licensing regulations. Certain items (such as room arrangement and safety practices) were changed to reflect a description of a 3 (minimally adequate) rating on several widely used environmental rating scales¹. Ten child care centers and five family child care homes participate voluntarily in the licensing model. State licensing specialists inspect these child care providers every 6 months and work closely with an early childhood specialist to make any necessary improvements. Participating providers receive cash incentives to help them meet quality goals; typical incentives payments are in the range of \$2,000 to \$3,000 every 6 months.

Training Models. The pilot subcommittee has worked to bring several important training resources into the county. Infant-Toddler Supervisor Training (on responsive caregiving) is a statewide initiative funded primarily through CCDF quality-improvement funds. Other opportunities funded by CCC include Child Development Associate (CDA) training and TEACHTM scholarships to help providers pay for CDA and associate degree courses.

Mini-Grants. CCC administers a mini-grants program for family child care providers who accept CCCAP children. Start-up grants (\$125) are earmarked for start-up costs and liability insurance while quality-improvement grants (\$500 to \$600) are available for the purchase of materials and equipment. Part of the criteria for selecting providers is the proportion of CCCAP children they care for.

Models to Provide Support for Children with Special Needs

Child Care Response Team (CCRT). Pilot partners realized that children with behavioral or developmental challenges were losing their child care arrangements with alarming frequency. In response, the pilot subcommittee developed and obtained funding for the CCRT, which intervenes at the request of child care providers or parents. CCRT works simultaneously with the child, the family, and the provider. As a condition of receiving CCRT services, child care providers must agree to an improvement plan based on the results of observation by an early childhood specialist. In addition, staff members refer families to early intervention services or specialized counseling, if such is needed. The CCRT serves children ages birth to 8, for up to 6 months per child. Between October 1999 and May 2002, CCRT has served 347 children.

Successes Of El Paso County's Child Care Pilot

Expanding the Supply of Infant-Toddler Care and Increasing Access to Subsidies.

El Paso County's child care pilot created at least 130 new infant-toddler slots in the community. Though the demand for infant-toddler care continues to exceed the

Table 1: 2002 Copayment Schedule for the Colorado Child Care Assistance Program, El Paso County, Colorado

Income Level ^a	Copayment
Less than 50% of poverty	6% of household income
50% to less than 75% of poverty	7% of household income
75% to less than 100% of poverty	8% of household income
100% to less than 130% of poverty	9% of household income plus \$5 per additional child
130% to less than 160% of poverty	10% of household income plus \$10 per additional child
160% to less than 185% of poverty	11% of household income plus \$15 per additional child

Source: El Paso County Department of Human Services.

^aFamilies on TANF cash assistance who are not employed are exempt from paying the copayment.

¹El Paso County drew from the Infant/Toddler Environmental Rating Scale (ITERS; Harms, Cryer, & Clifford, 1990), the Early Childhood Environmental Rating Scale (ECERS; Harms and Clifford, 1980), and the Family Day Care Rating Scale (FDCRS; Harms and Clifford, 1989).

supply, models developed by the pilot have demonstrated the feasibility of several strategies—the blending of funding sources, using alternative approaches to meeting health and safety standards, providing increased support for family child care providers, and providing child care in public school facilities.

Blending of funding sources. Pilot partners estimate that CCCAP reimbursement covers approximately half the cost of providing good-quality infant-toddler center care. Blending funds has proved crucial in making up the difference.

Waivers to state licensing requirements. The pilot has enabled El Paso County to apply for waivers to specific state licensing requirements that have created barriers to increasing the supply of infant-toddler care. Alternative solutions can often be found to safely remove barriers to providing infant-toddler care.

Increased support for family child care providers. Many pilot partners cited the Home Network as one of the pilot's greatest successes. By providing weekly reimbursement, technical assistance, and other support, 20 family child care providers have opened their homes to CCCAP children.

Implementation of infant-toddler programs in public school facilities. The pilot created 62 new infant-toddler slots in three public schools serving teen parents and parents with low incomes.

Streamlining the CCCAP application process. Because of the changes made in the application process in recent years, applying for and obtaining CCCAP funds is a more straightforward process.

Improving Quality

Pilot partners believe they have made significant strides toward the initiative's goal of increasing quality. They attribute quality improvements to the many training opportunities available to community providers and to the increased use of environmental rating scales in assessing quality and generating feedback to providers. For example, one pilot partner reported that when the county began using the environmental rating scales in 1999, many providers had poor health and safety practices and typically scored in the 2-to-3 (from not adequate to minimally adequate) range on the ITERS. By 2002, observers had noted increased interaction between caregivers and children, as well as ITERS scores that are often in the 4-to-5 range.

Most providers welcome the support and incentives offered by quality improvement initiatives. Staff involved in several of the pilot models reported that most providers like receiving technical assistance, support, and resources that come from participation in these quality initiatives. Financial incentives enable all types of providers to purchase new equipment and toys.

The Home Network has increased the professionalism of family child care providers. The Home Network has also helped to reduce the isolation family child care providers often experience working alone in

their homes. Training and development offered through the pilot has helped some home-based providers to begin developing professional networks.

Continuing Challenges

The demand for affordable infant-toddler care continues to

exceed supply. The shortage of infant-toddler care continues to be a significant challenge in El Paso County. The shortfall is especially acute for families with low incomes (because many providers do not accept CCCAP subsidies) and for families who need slots for several children.

CCCAP reimbursement rates are not sufficient to cover the cost of good-quality care. Many pilot partners cited the high cost of providing infant-toddler care as the main reason for the community's shortage of care. Many of those interviewed report that CCCAP reimbursement alone does not provide sufficient funds to offer good-quality infant-toddler child care. At the time of the site visit, county officials were focusing on whether they could raise the income limit for continuing eligibility, from 185% to 225% of the poverty level. This would reduce the severity of the "cliff effect" (see below).

The "cliff effect" that occurs when families exceed income eligibility limits for CCCAP puts good-quality care beyond the reach of most families.

Once its income exceeds 185% of poverty, a family loses eligibility for CCCAP. Especially for families with more than one child in care, the loss of CCCAP increases child care costs dramatically. According to local government officials, most of these families can no longer afford to pay for regulated child care, so their only option is informal kith-and-kin arrangements. Officials also reported that some parents refuse pay raises and promotions to avoid losing eligibility for CCCAP.

Funding may not be available to sustain some of the pilot models. Pilot partners raised concerns about their

Alliance for Kids partners attribute quality improvements to training opportunities and the use of environmental rating scales in assessing quality and generating helpful feedback.



ability to sustain some pilot models that are funded by grants, particularly the Home Network and the Child Care Response Team.

Partnerships and blended-funding arrangements pose some coordination challenges. Though blended-funding arrangements are essential to cover the cost of quality infant-toddler child care, aligning the goals, approaches, and application, reporting, and other procedures of different organizations and funding streams can be difficult.

Lessons From El Paso County's Child Care Pilot

Collaboration

Allowing local communities to design pilot models can increase collaboration and involvement at the local level. The state empowered local communities to identify their own communities' barriers, then design strategies tailored to the local community's strengths and needs. Pilot partners in El Paso County believe that this approach has facilitated increased collaboration among members of the early care and education community.

Strong support from local government officials is necessary. El Paso County DHS has contributed significant resources to the pilot. At several points, DHS has even used TANF funds to provide "bridge funding" to the CCRT during short gaps between funding cycles.

Relying on donated time may demand too much from pilot participants. Early on, the pilot subcommittee decided to put all available resources into services, rather than hire a staff coordinator. Some pilot partners believe this decision placed a tremendous burden on subcommittee members, who dedicated significant time to the pilot in addition to their "day jobs."

Increasing the Supply of Quality Infant-toddler Care

Some regulatory barriers to creating infant-toddler slots can be overcome without jeopardizing health and safety. While all pilot partners agreed that such regulations are both important and necessary for protecting young children, they also identified cases when these can be safely waived.

Providers must be able to combine funding streams to cover the cost of quality infant-toddler care. Virtually all the pilot partners agreed that CCCAP funding

alone is not sufficient to cover the cost of good-quality infant-toddler care, especially in child care centers.

Family child care homes can be an important source of quality infant-toddler slots. Offering quick-turnaround reimbursement to family child care providers, assistance with reporting procedures, financial management of subsidy contracts, and other incentives can increase the number of family child care providers who are willing to accept child care subsidies.

The El Paso experience illustrates the importance of local authority and decision-making power in identifying and overcoming barriers to good-quality infant-toddler care for families with low incomes.

Summary

El Paso's Child Care Pilot brings home the importance of local control over the design and implementation of infant-toddler pilot models. The authority and

decision-making power devolved to the local community helped to ensure that pilot models answered community needs and reflected community wants. Local control was integral to success in other areas, such as purview over funding. El Paso County was able to maximize funding streams for infant-toddler care through blending and other creative strategies; this was absolutely necessary in order to support the creation of new infant-toddler slots and to enhance the quality of caregiving. By the community, for the community, from the community: This localized approach to enhancing access and increasing the quality of infant-toddler care offers important lessons for successful grass-roots collaborations. ♦

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KANSAS AND MISSOURI EARLY HEAD START PROGRAMS:

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Sedalia, Missouri*

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Both the Kansas and Missouri Early Head Start programs sought to increase the number of good-quality infant-toddler child care slots available to families with low incomes in their respective grantee communities. This case study focuses on the experiences of two grantees—Project EAGLE, in Kansas City, Kansas; and the Children's Therapy Center, in Sedalia, Missouri. These state-sponsored initiatives follow the same program performance standards as federally funded programs. However, instead of providing all services directly, the programs supply most child development services through partnerships with community child care providers who agree to care for Early Head Start children in compliance with the performance standards.

Primarily using data collected during site visits to Kansas City, Kansas, and Sedalia, Missouri, in April 2002, this case study (Paulsell, Nogales, & Cohen, in press) provides an overview of each state's program and then describes the programs' partnerships with community child care providers, implementation successes and challenges of the partnerships, and lessons learned from these initiatives.

About the Communities

Kansas City, Kansas, and Sedalia, Missouri, are good examples of the wide variety in communities where state Early Head Start programs have been implemented: one community is urban, the other rural. There are differences also in the communities' demographic characteristics, their welfare programs, and child care subsidy systems.

Wyandotte County, Kansas, has a population of nearly 158,000, most of whom live in Kansas City (U.S. Census Bureau, 2001). Trends in the area's minority population show a growing number of Hispanics (approximately 16% of the population). The poverty rate among children is high: approximately 39% of residents under age 14 live in poverty (Kansas Action for Children, 2002). Moreover, estimates show that nearly a third of the 2,400 infants born annually in Wyandotte County are eligible for Early Head Start services because their families live below the poverty line.

In contrast, Sedalia, Missouri, is a small town in a rural area. The minority population is relatively small, under 8%. Pettis County (where Sedalia is located) contains about 39,000 people and covers 686 square miles. More than 13% of the population lives in poverty, including nearly 2,000 children under age 18 (U.S. Census Bureau, 2001).

Child Care Supply and Demand

Kansas. According to a Kansas Department of Social and Rehabilitative Services (SRS) official, the area has child care capacity for half the children aged birth to 5. Furthermore, the supply of regulated child care is inadequate in low-income neighborhoods, with only 13 child care centers located in these zip codes. Though community-based organizations have expressed interest in opening facilities in these neighborhoods, they have found that obtaining a license and meeting state standards prove too costly.



PHOTO: JANET BROWN MCCracken

Licensed family child care providers offer most of the community's regulated infant-toddler slots.

Missouri. Parents of infants and toddlers in Sedalia and the surrounding area also have a limited supply of affordable, good-quality providers to choose from. Relative to total child care slots, vacancies for infants and toddlers are extremely low. Although there is one accredited child care center in Sedalia, it accepts only children ages 2 to 5. According to program staff, most families rely on kith-and-kin care for their infants and toddlers, either because they prefer it or because they cannot find regulated arrangements.

Child Care Subsidy Program

Kansas. There has been no waiting list for child care subsidies in Wyandotte County for more than 5 years. For a family to be eligible for a subsidy, family income must be below 185% of poverty (unless the parent is enrolled in Transitional Assistance for Needy Families [TANF] or the

food stamp work program, has an open child protection case, or is a teen parent under age 18). Families with incomes at 100% of poverty or higher must make a copayment based on income and family size. Most families who receive child care assistance are working families rather than TANF clients.

In recent years, SRS has simplified the subsidy application process. SRS uses one generic application form for all its services (for example, food stamps or Women, Infants, and Children [WIC]), and clients complete only those pages that are applicable. Families can complete and submit the application in person at the SRS office, or they can mail it in.

SRS redetermines eligibility annually and does not increase the copayment amount at redetermination unless family income has increased more than two income brackets. This policy is intended to help families increase their disposable income without having to pay more for child care. Parents who are not employed at redetermination lose child care assistance.

SRS will provide subsidies for care provided by licensed or registered child care providers and for out-of-home care provided by relatives. At the time of the site visit, SRS had 390 subsidy agreements in place with providers; of these, 65 were with relatives.

Kansas reimburses child care providers for the hours children attend child care based on an hourly rate for each type of care. These rates are set on the basis of the results of market rate surveys conducted in each county. In February 2002, the state set subsidy reimbursement rates at the 65th percentile of market rates for licensed child care centers and family child care homes, and at the 60th percentile for registered family child care providers and unregulated relative providers.¹

¹Kansas offers lower child care subsidy reimbursement rates to registered providers and unregulated relative providers to encourage licensure.

at a glance

- In Kansas and Missouri, state-sponsored Early Head Start programs partner with community child care providers who follow Head Start performance standards.
- Child care partners receive reimbursement higher than state subsidy rates, bonuses, equipment and supplies, materials, and CDA and other training.
- Programs report that in order to improve child care environments and caregiving practices, it is best to work through one change at a time.

Missouri. Since welfare reform, the use of child care subsidies in Pettis County has increased, from 265 children in 1996 to 343 in 2000 (Citizens for Missouri's Children, 2001). At the time of the site visit, Pettis County did not have a waiting list for subsidies.

Missouri's child care subsidy program is administered by the Division of Family Services within the Department of Social Services (DSS). For applicants not on TANF, the division determines eligibility for child care assistance on the basis of household income.

Families with incomes at or below 121% of poverty are eligible.

According to a state DSS official, the state set a very low income threshold because its goal is to provide the subsidies to as many poor families as possible. Families on TANF must make a copayment of \$1 a year; other families' copayments are based on income and type of care. DSS redetermines eligibility annually. The department has made the process relatively easy for parents, who need only to complete a one-page form and submit it by mail.

Missouri uses market rate surveys conducted every 2 years to set reimbursement rates though, because of budget constraints, the state has not increased reimbursement rates since 1996. In addition, Missouri has implemented a tiered reimbursement system. Providers who care for certain populations (e.g., children with special needs) or offer specific types of care in high demand (e.g., weekend care) receive enhanced subsidy payments.

History of the State Early Head Start Programs in Kansas City and Sedalia

In 1998, the governor of Kansas signed into law a 5-year Early Head Start initiative, funded at \$5 million annually through a transfer of TANF funds into Kansas' Child Care and Development Fund (CCDF). Development of the initiative was spearheaded by the governor's office in recognition of the increased need for quality child care as TANF work requirements went into effect. By August 1999, 13 grantees had begun serving families. By July 2002, Kansas had invested more than \$27.5 million in its Early Head Start program, while providing quality child care to 2,875 children through the program.

Using Kansas's Early Head Start program as a model, Missouri developed its own Early Head Start program. In 1998, the Missouri legislature passed H.B. 1519, which allocated a portion of state gaming revenues to an early child care and development fund. The state recognized that the most pressing need for quality child care rested with the birth-to-3 population, and decided to channel \$5.5 million of the gaming revenues to a state-funded Early Head Start program. Most of Missouri's 11 grantees began serving families in 2000, after a 1-year planning period.

The state legislatures of Kansas and Missouri have funded Early Head Start programs to provide quality child care for infants and toddlers.

Although the state Early Head Start programs in Kansas and Missouri are very similar, some key differences are evident. The state Early Head Start program in Missouri does not fund services for 3-year-olds, as Kansas' program does. Moreover, although the Kansas legislature funded the program for a set dollar amount for 5 years, the authorizing legislation for the Missouri program allows for a budget that depends primarily on gaming revenue; a smaller portion comes from TANF transfers. Thus, the

amount of Missouri's Early Head Start funding can fluctuate from year to year if gaming revenues are not sufficient to fully fund the program's budget.

Project EAGLE, in Kansas City, Kansas

Project EAGLE, located in Kansas City, Kansas, was founded in 1989 as a program of the University of Kansas Medical Center, whose mission it was to serve families with low incomes who have infants and toddlers. Families are drawn from several communities in Wyandotte County. The agency serves 200 children and pregnant women annually through the state and federal Early Head Start programs. Of these, 120 are funded with federal dollars, 64 with state dollars, and 16 with Kansas City, Kansas, municipal dollars.

The Children's Therapy Center in Sedalia, Missouri

The Children's Therapy Center was founded in 1956 to meet the needs of families who traveled from outlying areas to the hospital in Sedalia to obtain services for children with disabilities. Today, the agency's mission is to meet the needs of adults and children with disabilities in the community. In April 2002, the Center had a staff of 260, 43 of whom worked exclusively on early childhood programs for children aged birth to 5 and their families.

Under Part C of the Individuals with Disabilities in Education Act, services are provided to young children and their families in an eight-county area through the Family and Child Development Department at the Children's Therapy Center. The Children's Therapy Center received a federal Early Head Start grant in fall 1999 to serve 70 families—20 in a child care center operated by the agency and 50 through home-based services. With funding from the Missouri Early Head Start program, the Center serves an additional 40 families through partnerships with community child care providers.

Strategies For Developing Partnerships

Project EAGLE and the Children's Therapy Center operate both state and federal Early Head Start programs. In designing their state programs, both agencies integrated the two programs to some degree. However, they took different

NATIONAL INFANT & TODDLER CHILD CARE INITIATIVE

In September 2002 the Child Care Bureau, Administration for Children and Families, Department of Health and Human Services, awarded a contract to ZERO TO THREE to implement the National Infant & Toddler Child Care Initiative. The Child Care Bureau developed the Initiative in response to a FY 2001 survey of Child Care Development Fund (CCDF) Administrators. The results of the survey indicated that the improvement of the supply and quality of care for infants and toddlers was one of the top needs for technical assistance.

The National Infant & Toddler Child Care Initiative is designed to support CCDF state and territory Administrators in their efforts to effect system-wide improvements in infant and toddler child care. This 3-year project will work directly with 10 states and territories per year, for a total of 30 states and territories. It is envisioned that technical assistance through this Initiative will:

- be tailored to meet the needs of each participating state or territory,
- help states and territories work towards implementing existing plans to improve the infant and toddler child care system or develop new plans if none exist,
- provide free access to consultants to the states and territories, and
- help states and territories evaluate progress towards their self-identified goals.

In addition to the technical assistance, states and territories that participate will receive \$2,000 to develop products or complete tasks associated with their goals.

The Child Care Bureau has selected the initial ten states and territories for participation: Arkansas, Connecticut, Kansas, Michigan, Montana, New Jersey, North Carolina, Washington, Washington DC, and West Virginia.

The National Infant & Toddler Child Care Initiative will also produce materials that feature infant and toddler child care issues and trends including fact sheets, issue briefs, and other relevant materials that will be available to all 50 states and all territories.

States and territories are required to develop or designate a team to work within the state or territory on infant and toddler child care system improvements. Teams will determine their own goals and priorities, whether in the area of professional development, regulatory practices, interagency collaboration, public awareness, subsidy policy, etc. CCDF administrators can designate an existing collaboration or team if it includes the required membership.

States and territories that are facing significant challenges as well as those that have been able to achieve significant results are encouraged to participate in the Initiative. For more information please call Dianne Stetson, Project Director, at 202-638-1144, ext. 677, or Susan Medina, Program Associate, at 202-638-1144, ext. 676.



National
Infant & Toddler
Child Care
Initiative
OF
ZERO TO THREE

approaches to providing comprehensive services to families and supporting partner child care providers—each approach reflecting the needs and realities of their respective communities.

Kansas: Project EAGLE. In Kansas City, Project EAGLE has recruited and developed partnership agreements with numerous community child care providers. At the time of the site visit, the agency had established partnerships with 14 child care centers and 11 family child care homes. A child care coordinator oversees support for these partnerships. She is responsible for recruiting partners, developing partnership agreements, coordinating a Child Development Associate (CDA) training program, keeping track of vacancies, and supervising two child care specialists who support the providers.

One child care specialist serves as the program liaison for child care centers, while the other focuses on family child care providers. These specialists visit each child placed with the providers in their caseload twice a month. During these visits, the specialists observe the child, offer feedback and technical assistance to the child's teacher, help out in the classroom if needed, and model developmentally appropriate caregiving.

Family advocates serve as the program's primary contact for families and are responsible for coordinating all the services that families receive. They conduct home visits to families receiving child care through the partnerships, periodically assess children's development, and work with families to develop family partnership agreements that include the parents' goals for their infants and toddlers.

Missouri: The Children's Therapy Center. At the time of the site visit, the Children's Therapy Center had seven child care partners—five child care centers and two family child care homes. Like Project EAGLE, the Children's Therapy Center employs a child care coordinator to oversee the partnerships with child care providers. At the Children's Therapy Center, however, the child care coordinator also oversees services for families. She is responsible for recruiting partners, developing partnership agreements with providers, and supervising the work of four Partner Advocate Liaisons (PALs).

Three of the PALs are responsible for providing support and technical assistance to a caseload of child care providers; they visit centers and family child care homes weekly. Unlike Project EAGLE's child care specialists, however, the PALs also provide services to families, primarily during monthly home visits. During these visits, PALs work with parents to develop individual learning plans for children, complete regular developmental assessments using the *Ages & Stages Questionnaires* (Bricker & Squires, 1999), and provide other family development services.

The fourth PAL does not have a caseload of providers or families. Instead, she provides specialized services to child care partners as needed.

Recruiting and Selecting Child Care Partners

Kansas. Because Project EAGLE had longstanding relationships with several community child care providers before it began the Kansas Early Head Start program, it did not have to recruit heavily to find providers when the state program started. To recruit new partners, the child care coordinator relies primarily on word of mouth though the coordinator actively recruits new partners when specific needs arise (e.g., in a specific area of the county).

Missouri. Unlike Project EAGLE, the Children's Therapy Center had no previously established partnerships with community child care providers when the state program began. To recruit providers, the child care coordinator posted flyers and placed an advertisement in the local newspaper, inviting child care providers to attend an orientation session to discuss the partnership. Afterward, the child care coordinator met individually with interested center directors and family child care providers to discuss the details of the partnerships.

Project EAGLE and the Children's Therapy Center require partners both to have state licenses and to be in good standing with the licensing agency. While neither agency requires providers to provide high-quality care when they begin the partnership, providers must be willing to work toward improving quality and meeting the performance standards.

Both agencies reported that most partnerships have worked well, but each has ended a few partnerships because providers were unwilling to work on meeting the performance standards.

Partnership Agreements

Project EAGLE and the Children's Therapy Center develop formal partnership agreements, or contracts, with their child care partners. These agreements document in writing the expectations of both partners, the resources each partner will bring to the partnership, and the activities each partner agrees to carry out through the partnership.

Partnership agreements detail the standards that child care partners must work toward meeting. Because state Early Head Start programs must operate in compliance with the federal Head Start Program Performance Standards, the agreements focus heavily on those requirements and how the partnership will achieve compliance with them. Specifically, the partnership agreements developed by both Project EAGLE and the Children's Therapy Center must meet requirements for state licensing, in addition to:

1. **Participation in Visits by Early Head Start Staff.** Providers must allow program staff to visit regularly, as well as provide needed technical assistance.
2. **Implementing Developmentally Appropriate Practices.** Partners must implement developmentally appropriate practices, such as holding infants while bottle-feeding them and putting them down on the floor to play. Programs discourage providers from using restrictive equipment, such as swings and walkers.
3. **Compliance with the Head Start Program Performance Standards.** Partners must work toward compliance with the performance standards, such as implementing developmentally appropriate practices, family-style dining, health and safety procedures, requirements for teacher credentials, and ratio and group size limits (four children per teacher and eight children per group). Neither program requires progress in a particular time frame or outlines minimum thresholds. They are willing to work with providers to raise their quality-of-care standards as long as providers show improvement and dedication.
4. **Teacher Credentials.** Lead teachers must obtain a CDA credential or have a higher degree within 1 year of hire or the start of the partnership. Both programs provide training and support for obtaining a CDA.
5. **Monitoring Children's Development.** Child care teachers must maintain, for each child, daily log sheets that track eating and sleeping patterns and record regular observation notes. They also must maintain portfolios of each child's log sheets, service plans, assessments, and artwork or other projects. Teachers must develop lesson plans that incorporate developmentally appropriate activities and support children's individual learning goals.
6. **Communication with Parents.** Both programs require child care partners to communicate regularly with parents.
7. **Recordkeeping.** Both programs require providers to maintain attendance and other administrative records.

To support child care partners in their efforts to improve quality and comply with the Head Start Program Performance Standards, Project EAGLE and the Children's Therapy Center provide partners with reimbursement for child care services, equipment and supplies, and training and technical assistance.

Partnership agreements describe the level of support that child care partners receive from the programs, including the following:

8. **Reimbursement.** Project EAGLE and the Children's Therapy Center purchase slots for Early Head Start children from partner providers. They reimburse providers at higher rates than those paid by state child care subsidy systems and provide reimbursement more quickly. Both programs negotiate rates with each child care partner individually, rather than setting standard rates. In addition, each pays for days when children are absent; state subsidy systems do not.
9. **Bonuses.** The Children's Therapy Center pays higher rates to accredited providers and has, in the past, provided incentive bonuses to partners that met quality improvement goals. Project EAGLE awards providers a \$400 mini-grant when teachers complete CDA training.
10. **Equipment and Supplies.** Both programs purchase equipment (such as changing tables, rockers, and cribs), indoor and outdoor play equipment, and toys that providers need to ensure quality care and to comply with the performance standards.
11. **Lending Libraries.** Both programs maintain lending libraries of curricula and lesson planning materials, children's books, toys, and health and safety materials and equipment.
12. **CDA and other training.** Both programs provide CDA training free of charge, pay for the cost of applying for the CDA credential, and pay for substitutes while teachers attend CDA or other training.

Technical Assistance and Training for Child Care Providers

Although staff members from both programs visit partner providers regularly, Project EAGLE and the Children's Therapy Center take different approaches to conducting these technical assistance visits. Child care specialists from Project EAGLE (Kansas) visit each Early Head Start child in child care twice a month; the focus of their visits to child care partners is on the services provided to a particular child. In contrast, PALs from the Children's Therapy Center (Missouri) visit providers weekly, regardless of how many Early Head Start children are in care. Their visits focus on providing technical assis-

tance to the child care teachers and working to implement the performance standards, rather than on the services provided to an individual child.

The primary focus of technical assistance visits in both programs is to work toward meeting the performance standards. Child care specialists and PALs stressed the importance of working incrementally, in a strengths-based manner, to implement them. Providers become overwhelmed if they are expected to make too many changes at once. The first priority for both programs has been to implement health and safety standards, then work on the room arrangement and the caregiving environment.

Implementing standards that require changes in caregiving practices takes more time. Child care specialists and PALs said they try to introduce one new standard at a time and gradually work with providers on ideas for implementing it. They encourage providers to implement practices that foster children's development and self-help skills, and that promote positive relationships between children and their caregivers. For example, both programs work with providers on issues like holding infants while bottle-feeding, implementing family-style dining with toddlers, talking more to children, and giving them individual attention.

Both programs incorporate quality assessments of their technical assistance efforts. In Sedalia, Missouri, the PALs conduct an annual observation using the Infant-Toddler Environmental Rating Scale (ITERS; Harms, Cryer, & Clifford, 1990) or Family Day Care Rating Scale (FDCRS; Harms and Clifford, 1989) to gauge providers' progress in improving quality. In Kansas City, child care specialists distribute the ITERS or FDCRS to providers biannually and ask them to conduct self-assessments.

CDA Training Programs

Kansas. In 1998, Project EAGLE and Kansas City Community College began a CDA preparation program exclusively for child care providers that partner with Project EAGLE. The classes are offered once a month, from February through October on Friday evenings and all day Saturday, and include Fundamentals of Early Childhood Education, Infant and Toddler I, and Infant and Toddler II. Upon completion of each class, students receive three college credits (nine total for the program) that can be applied toward an associate's degree in early childhood education. To enroll in the program, teachers must have a high school diploma or a GED.

CDA students receive intensive support while they are

Technical assistance providers in Kansas and Missouri work first on health and safety standards, next on room arrangement and the caregiving environment. Changes in caregiving practices take more time.

in the program. A program coordinator from the community college administers the program; she handles all program logistics, helps students who need tutors obtain them from the Learning Resource Center, helps students enroll in English as a Second Language (ESL) courses if needed, obtains college identification badges for the students, takes them to the college bookstore, and helps them access college computer labs. She also serves as the academic adviser for all the students.

At the end of the coursework, the community college coordinator helps students assemble and submit all needed paperwork for the CDA application. To obtain the CDA credential, students must complete 120 hours of coursework, prepare a portfolio, pass an oral and written exam, write an autobiography, become certified in CPR and first aid, and pass an observation by a CDA examiner. At the time of the site visit, the program boasted a 95% success rate for students who had enrolled in the program. By May 2002, 65 teachers had obtained CDAs.

Kansas' Project EAGLE Early Head Start program boasted a 95% success rate for child care providers in the CDA preparation program it sponsored with Kansas City Community College.

Missouri. The professional development coordinator at the Children's Therapy Center teaches CDA classes for child care teachers on staff and from partner child care providers. Classes are held for 3 hours on two afternoons a week. However, in part because of high staff turnover in partner child care sites, few students finished the coursework. In addition, some center directors sent staff to training on a rotating basis, so that all teachers had an opportunity to attend training. As a result, teachers from these centers did not attend sufficient hours for them to apply for the CDA credential. At the time of the site visit, the coordinator reported that 2 of 10 students enrolled in the CDA program were expected to complete all the requirements and obtain their CDA.

During the site visit, the coordinator said that she planned to offer courses in six-week blocks in the coming year and to allow providers to commit to each block separately. She will also ask centers to select only one or two teachers to enroll in each block, to ensure that they accumulate enough hours to apply for the credential. At the time of the site visit, students did not receive college credit for completing the CDA course.

Community Initiatives That Support The Partnerships

Kansas. Project EAGLE and its child care partners receive support from the following community programs:

- **Heart of America Family Services.** This nonprofit agency provides child care resources and referral and other services to families in the greater Kansas City

area. The agency administers a range of support initiatives for child care providers:

- **The Infant-Toddler Project.** An infant-toddler specialist on staff organizes provider trainings, on-site technical assistance, quality assessments using the ITERS and FDCRS, and outreach to encourage providers to add infant-toddler slots.
- **TEACH™ Scholarships.** The Teacher Education and Compensation Helps (TEACH™) program offers scholarships to child care providers as an incentive to encourage professional development in the child care field. The scholarships cover 80% of tuition costs. Students also receive three hours of compensated time and mileage reimbursement. To qualify, scholarship recipients must commit to remaining in their current position for 1 year after completing coursework. After receiving a CDA or associate's degree, family child care providers receive a \$300 bonus, and staff from child care centers receive either \$300 or a 2% salary increase.
- **Child Care WAGES Project.** The WAGES initiative aims to reduce child care teacher turnover and promote professional development by providing salary supplements to teachers who meet experience and/or education requirements. Providers apply for funds through a Smart Start committee led by United Way; preference is given to accredited providers or those in the process of obtaining accreditation.
- **Quality Improvement Enhancement Project.** This project offers training opportunities for family child care providers to share strategies in making their child care business profitable and communicating more effectively with parents. Also available are family child care provider grants to funding the purchase of new equipment and supplies.
- **Accreditation Project.** Through this initiative, 14 full-time staff provide technical assistance to providers working on obtaining accreditation. The program also provides grants for equipment purchases and facilities improvements, ranging from \$5,000 to \$25,000, to providers undergoing accreditation.
- **Foster grandparents.** Foster grandparents serve as volunteer classroom assistants in several partner child care centers. They help teachers with feeding and rocking infants, reading to children, cleaning, and other tasks.
- **The Infant-Toddler Program.** Staff members from the Infant-Toddler Program, Kansas City's early intervention program for infants and toddlers with special needs (Part C), work on-site in partner child care centers to serve Early Head Start children with

special needs, and coordinate with Project EAGLE and child care staff to develop and implement individual family service plans.

Missouri. As a rural community, Pettis County has fewer support initiatives for child care providers than does Wyandotte County, Kansas. However, the Children's Therapy Center collaborates closely with three community initiatives to enhance support for families and providers:

- **EduCare.** Funded by the state DSS, this initiative provides technical assistance and support services to 62 child care providers (primarily family child care homes) to promote developmentally appropriate practices.
- **Parents As Teachers.** This parent education and family support program collaborates with the Children's Therapy Center to provide child development and parent education services to Early Head Start families; families receive monthly visits from Parents As Teachers staff.
- **First Steps.** Also administered by the Children's Therapy Center, First Steps is the early intervention program (Part C) in Pettis County for infants and toddlers with special needs. Staff from Early Head Start and First Steps work closely to identify and assess children with special needs and to plan and coordinate services across the two programs. First Steps staff provide on-site therapies to children in their child care settings and in families' homes.

Successes of the Partnerships

Improved Quality. The Successes of these partnerships affected the communities service in four main areas.

Improved quality of care provided in partner child care sites. Program staff report that child care partners have made significant strides in numerous aspects of quality, especially in those of health and safety. For example, in Missouri, PALs reported that teachers now hold children in rocking chairs while giving them bottles, and no longer use walkers or swings.

"Ripple" benefits of the program. The impact of the program goes beyond Early Head Start children—many non-Early Head Start children who receive care from the partner child care providers also reap the benefits of increased quality of care. All children in the classroom benefit from teachers' training and new skills. All children enjoy new toys, equipment, and improvements to outdoor

play areas provided through the partnerships. Similarly, reductions in group size and child-teacher ratios benefit the entire classroom.

Ongoing relationships and support critical to quality gains. Regular observations and feedback were cited as crucial to helping participating teachers in Kansas translate what they learned during training into their daily practice with children in their care. In Missouri, center directors and community partners credited the supportive attitude and intensive coaching provided by the PALs with helping providers implement quality practices.

Increased Access to Good-Quality Infant-Toddler Care for Families With Low Incomes

Increased supply of regulated infant-toddler slots in their communities. In Kansas and Missouri, partner providers have increased the number of infant-toddler slots offered. Providers were even willing to expand once knew they had a stable source of funding from the state Early Head Start program.

Increased access to quality care for populations with unique needs. In Kansas, teen parents attending school but not working can now access infant-toddler care through the Early Head Start-child care partnerships. Parents over age 18 are not eligible for a state subsidy to pay for child care while they attend school. The state Early Head Start program, however, can cover these costs, offer these infants and toddlers a nurturing child care setting, and support parents who want to stay in school.

Improved Support for Children With Special Needs and Their Families

Improved support for children with special needs and their families, especially in child care settings. Part C providers in both communities report that support from Early Head Start has increased partner providers' receptivity to Part C children. Moreover, they believe that the CDA and other training has enabled providers to better meet the needs of children with special needs in their care.

Increased Community Collaboration

Increased collaboration among service providers. State Early Head Start programs and child care partnerships have raised community awareness of the importance of quality child care and increased collaboration

All children enjoy new toys, equipment, and improvements to outdoor play areas provided through the partnerships. Similarly, reductions in group size and child-teacher ratios benefit the entire classroom.

between programs, providers, and other community child care initiatives.

Continuing Challenges

Despite their successes, the programs faced several challenges.

Improving Quality

Fully implementing the performance standards.

Program staff and partner providers reported that implementing the Head Start Program Performance Standards takes significant effort and time. Teachers, especially those without formal training in early childhood development, need time and support in order to implement new curricula in the classroom and learn how to individualize activities for children. In addition, it takes time for programs to supply all the equipment that providers needed.

Reducing child-teacher ratios poses the most significant challenge, especially in family child care homes.

Even though state licensing standards permit higher ratios, Early Head Start programs must comply with the 4-to-1 child-teacher ratios required by the performance standards. Although Early Head Start programs offer higher reimbursement rates, they cannot afford to compensate providers fully for the revenue they would lose by adhering to these ratios. This is an especially difficult challenge for family child care providers because of the small groups of children they serve.

Teacher Turnover

Frequent teacher turnover has made sustaining gains in quality a challenge. Especially in Missouri, several partner providers have experienced high teacher turnover, as other entry-level jobs in the community offer higher wages than child care. Frequent turnover has made it hard to sustain continuity of care for children and improvements in quality caregiving practices.

Meeting the CDA Requirement

Turnover and scheduling challenges pose barriers to meeting the CDA requirement. The programs in both Missouri and Kansas have experienced challenges with scheduling CDA training at times that worked for all staff. It has also been difficult to get teachers to attend classes regularly and obtain sufficient hours to apply for the credential. Turnover exacerbates this issue; when teachers leave, they take the training with them.

Difficulty finding substitute teachers. Center directors report that they have struggled to find qualified substitutes who were available to work while teachers attended CDA training.

Extra Duties for Teachers

Difficulty finding the time to complete additional activities required by the partnerships. The partnerships with Early Head Start require that child care teachers take on additional duties, such as documenting children's activities and progress, developing lesson plans, and taking observation notes. Some teachers have been overwhelmed by these additional duties, especially the increased paperwork.

In Missouri, staff members report that, although services between Early Head Start, the Parents As Teachers home visitors, child care providers, and other community service providers were fairly well coordinated, it was sometimes challenging to maintain communication with all service providers.

In Kansas, conducting home visits has been a particularly challenging obstacle for some teachers. Partner teachers and family child care providers must hold two of four required parent-teacher conferences in the families' homes. Most teachers expressed some reluctance about them. Although the Early Head Start programs pay staff members overtime to conduct these visits, teachers said that they did not have time after work because of family responsibilities or that they were too tired after working a full day.

Coordination and Communication

Efficient, effective communication and coordination between families, program staff, and providers has, at times, been challenging. In Kansas, some center directors reported having been confused initially about lines of communication between the program, providers, and families. In some cases, providers or program staff assumed that all relevant persons knew about a particular family situation, when in fact they did not. In Missouri, staff members report that, although services between Early Head Start, the Parents As Teachers home visitors, child care providers, and other community service providers were fairly well coordinated, it was sometimes challenging to maintain communication with all service providers.

Blending funding streams can be difficult because fiscal years and reporting requirements differ.

Although programs welcome the opportunity to receive funding from various sources, blending these funding streams is challenging as each has its own reporting requirements.

Lessons From State Early Head Start Programs

The experiences of Project EAGLE and the Children's Therapy Center can inform the efforts of other states seeking to implement similar initiatives. They also can be useful to Early Head Start grantees and other community organizations that work in partnership with child care providers on quality improvement and increasing access to infant-toddler care for families with low incomes. This section highlights several lessons derived from the grantees' experiences implementing the Kansas and Missouri Early Head Start programs.

Changes necessary for meeting the Head Start performance standards are best made incrementally.

Program staff and partners agreed that it is not realistic to expect child care providers to make multiple changes in their environments and caregiving practices in a short time. Instead, they need to work through one change at a time, building on what they have accomplished to achieve new goals.

Improving quality requires sustained effort and significant investment. Program staff and child care partners believe they have made significant improvements in the quality of care they provide, through sustained effort—participating in regular technical assistance visits, obtaining CDA credentials, and working step by step to implement the performance standards. Child care partners stress that the substantial resources invested by the state Early Head Start programs were critical to making these changes.

Funding provided through the state Early Head Start programs may not be sufficient to subsidize required low ratios and group sizes. Both Project EAGLE and the Children's Therapy Center pay their partners at higher rates than those of their state child care subsidy programs. They also offer more stable funding, because they pay for care when children are absent. These differences, however, are not enough to compensate providers for lost revenue associated with reducing ratios and group sizes to required levels. This is especially true for family child care homes, where the reduction in group size concomitantly reduces the provider's income substantially.

Regardless, many child care providers are willing to add infant-toddler slots if they are guaranteed sustained funding and support. Despite the intensity and high cost of providing infant-toddler care and the additional work associated with the partnerships, many providers were willing to maintain or even expand their infant-toddler slots with assurances that reimbursement and support from Early Head Start would continue.

Strong communication systems are necessary.

Communication was a recurring theme during the site visits,

perhaps because the state Early Head Start programs require coordination among multiple parties to function effectively. All involved in the partnership—parents, teachers, and program staff—underscored the importance of having up-to-date information and knowing whom to contact if issues arose.

Summary

The experiences of the Early Head Start programs in Sedalia, Missouri, and Kansas City, Kansas, illustrate how a well-organized network of community partnerships can have a profound impact on both the quality of infant-toddler care and families' access to such care. By partnering closely with local providers and offering stable funding, ongoing support, training, and technical assistance, Early Head Start has had an important ripple effect on these communities. Every child enrolled with participating providers has benefited from more responsive, developmentally appropriate care, from enhanced facilities and equipment, and from better trained teachers and caregivers. Such partnerships serve as an important example to parents and others of what quality care truly looks like. ♦

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PHOTO: JANET BROWN MCCrackEN

MOUNTAIN AREA CHILD AND FAMILY CENTERS, BUNCOMBE COUNTY, NORTH CAROLINA

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The Mountain Area Child and Family Centers (MACFC) is the product of efforts by local community members in Buncombe County, North Carolina, to develop a high-quality child care center to serve children aged birth to 5 years. Its grass-roots, community-based and private-sector origins make it unique among the programs studied in the in the ZERO TO THREE/Mathematica research effort. This case study primarily uses data collected during a site visit to Buncombe County in June 2002, and describes the development of MACFC, the services it provides to children and families, the other community initiatives that support MACFC, its implementation successes and challenges, and lessons learned.

About the Community

Buncombe County, North Carolina, has more than 200,000 residents, most of whom live in the city of Asheville. The overwhelming majority of the population is white,

although the number of Hispanics has grown rapidly over the past decade—almost 400% (U.S. Census Bureau, 2001). According to program staff, approximately 1,200 children in the county are eligible for Early Head Start services, with 20% of the county's children living in poverty.

at a glance

- Rural areas may have distinct child care needs—during the tourist season, for example, or for new immigrant populations.
- Concerned retirees can mobilize community resources and build public support for high-quality child care.
- Public funds increased access to high-quality care.
- A college as community partner kept provider education a central focus.

Child Care Supply and Demand

Buncombe County Child Care Services (BCCCS), the local resource and referral agency, receives 150 to 200 calls per month from parents looking for child care. Demand for child care is highest in the summer months, when employment in the tourism industry peaks. BCCCS reported that the county has a sufficient supply of care for preschool-age children, but the demand for infant-toddler slots is higher than the number available. Supply is especially low for families who need care in certain regions of the county, as often the location of available openings does not match up with the areas where the need for care is greatest. Families seeking Spanish-speaking child care providers find there are few in the county. As in many areas of the country, children with social-emotional challenges, for example, those children exhibiting aggressive and disruptive behavior, frequently have difficulty maintaining child care placement. In addition, there are not enough providers in the county who can offer care for children with special needs.

Child Care Subsidy Program

BCCCS provides child care subsidies to approximately 1,425 families (about 2,400 children) each month. An estimated 25% to 30% of these are working-poor families who do not receive any other form of public assistance. To fund the child care subsidy program, BCCCS pools the county's subsidy allocation from the Department of Social Services and the Smart Start initiative into one fund. Families must make a co-payment equal to 8% to 10% of their income, depending on family size. Families must reapply for subsidized child care annually and report any changes affecting their eligibility to the agency as they occur.

The level of funding for child care subsidies is not sufficient to meet the need for child care assistance in the county. At the time of the site visit, approximately 650 children were on the waiting list.

Child Care Subsidy Reimbursement Rates

North Carolina establishes market rates for subsidy payments at the 75th percentile using the data collected from a survey of all regulated child care providers in the state. Providers are asked to report the rates they charge parents who pay privately. Providers participating in the Subsidy Program can be paid the rate they charge privately paying parents or the market rate, whichever is lower. About 153 licensed child care providers participate in the child care subsidy program, well over 90% of licensed providers in the county.

History of MACFC

MACFC is the product of a grass-roots community effort to address the county's unmet need for good-quality child care. Its development spanned nearly a decade, and reflects the work of a small group of concerned citizens—mostly retirees in the area—who mobilized extensive community resources to design, build, and operate a state-of-the-art child care center in an underserved area of Buncombe County. Though this initiative may be hard to replicate,

researchers included it because they believe it provides important lessons for other private-sector entities, such as the business community, faith-based organizations, or community foundations, that seek to improve infant-toddler care in their communities.

The group involved in establishing MACFC, called the

Swannanoa Valley Voice for Children, raised more than \$3 million to develop, build, and open a high-quality child care center. See the sidebar (p.29) for a timeline of key events in the center's development. The Swannanoa Valley Voice for Children pursued community collaboration from its inception. In addition to conducting a vigorous community education and outreach campaign to gain support for its goal of establishing a child care center, the organization turned to institutions in the community for specific contributions. For example, the group consulted extensively with BCCCS on developing a child care center and sought guidance on which experts could provide advice at various stages of the center's development. In addition, the group identified Warren Wilson College as an ideal partner for helping the group meet one of its goals for the center: providing education for the broader early childhood community. Warren Wilson is a private, 4-year, liberal arts college with a strong early childhood education department; it is located in Asheville, North Carolina. Ultimately, the MACFC was sited on college land.

MACFC: Structure and Services

MACFC opened its doors in January of 2001 prepared to serve infants and toddlers in the 105 square miles that comprise rural Buncombe County (outside the city of Asheville). In June of 2002, it had 76 slots, about half for infants and toddlers. At this time, it also had a waiting list of approximately 90 children, more than half of whom were infants or toddlers.

Since its inception, the board and staff of MACFC have made a firm commitment to providing high-quality care. This is reflected in both the state-of-the-art, child care facility they built and in the operation of the center. MACFC employs 18 teachers, with infant-toddler ratios of four children per teacher. Lead teachers must have an associate's or bachelor's degree in early childhood education or

In Buncombe County, retirees mobilized extensive community resources to design, build, and operate a state-of-the-art child care center in an underserved area.

a related field. Assistant teachers must have similar credentials, be enrolled in an early childhood education program, or working on a Child Development Associate credential. Board members sought to make MACFC the "employer of choice" for early childhood professionals in the community by providing a competitive compensation package and supporting ongoing professional development. This strategy has led to greater continuity of care for children and families; MACFC's staff retention rate in 2001 was 85%, compared to 50% for child care centers statewide.

Services provided to families—in addition to developmentally appropriate care—include family support and parent involvement opportunities, health services for children and families, and services for children with special needs. Teachers develop weekly lesson plans which are flexible and responsive to children's interests. Teachers also identify individual goals for each child that are updated regularly and reflect results from regular assessments using the *Ages & Stages Questionnaires* (Bricker and Squires, 1999), observations, and the child's interests. Staff maintain portfolios for each child which contain the child's artwork, photographs, observation notes, assessments, and other information. Parent-teacher conferences are scheduled every 3 months. To promote continuity of care and the development of nurturing relationships between children and teachers, as children grow and move on to new rooms, some of their teachers move up with them.

Services provided to families—in addition to developmentally appropriate care—include family support and parent involvement opportunities, health services for children and families, and services for children with special needs.

The board also made a commitment to serving children with special needs; when researchers visited the center, a substantial number of infants and toddlers with a range of special needs were receiving care. These included "failure to thrive" babies, children with speech or other developmental delays, children with behavioral difficulties, and children with other disabilities. About 15% of all the children enrolled at the center had special needs.

The center is committed to serving families from diverse income levels. At the time of the site visit, about half of families were privately paying, and half were families with low incomes. Many of these families had obtained child care subsidies. The center also offers limited scholar-

ships to families who need financial aid, usually to cover gaps in subsidy coverage or while families are on the subsidy waiting list.

Support from Smart Start

MACFC has drawn on numerous community resources and has collaborated with a range of local organizations to enhance the services it provides. Community organizations have donated everything from funds to handmade quilts. MACFC also benefits from collaboration with Buncombe County's Smart Start initiative. Launched in 1993, Smart Start is a statewide public-private initiative that provides local communities with funding to support programs that promote young children's healthy development and school

TIMELINE OF KEY EVENTS: MACFC

Date	Event
Fall 1992	Leadership Swannanoa Valley held at Warren Wilson College
Fall 1993	Head Start classroom opens at W. D. Williams Elementary School
1993	Local survey indicates high need for good-quality child care in Buncombe County
1993	Swannanoa Valley Voice for Children formed
1995	Swannanoa Valley Voice for Children hires a design consultant and an architect to design child care center
1996	Warren Wilson College grants a renewable lease at one dollar a year for 40 years
May 1996	Board hires fund-raising consultant and launches capital campaign to raise \$3.5 million
April 1997	\$1.0 million in donations received
February 1998	Board changes name to MACFC
June 1999	Capital campaign goal met; \$3.6 million raised
July 2000	Board hires executive director
September 2000	Warren Wilson College students and community volunteer build playground
January 2001	MACFC begins providing child care
September 2001	MACFC obtains Early Head Start grant
September 2002	MACFC begins Early Head Start program and opens a satellite center in southwestern Buncombe County

readiness, such as quality child care, family support services, and health care. MACFC benefits from a number of Smart Start-funded initiatives in Buncombe County, including:

- **Health Insurance Supplement.** Smart Start provides up to \$200 per month to cover a portion of health insurance costs for child care teachers who meet specific education criteria and work at least 30 hours a week with children ages birth to 5 years. MACFC accesses these funds to provide health insurance for its teachers.
- **Teacher Education and Compensation Helps (TEACH™).** This initiative encourages professional development by paying 50% to 80% of child care teachers' tuition for early childhood college courses. For participating staff, MACFC planned to pay the remaining 20% to 50% of their tuition costs.
- **Child Care Health Consultants.** With support from Smart Start, the Buncombe County Health Center has registered nurses on staff who provide consultation on health issues and child development to child care providers.
- **Early Childhood Dental Care.** A dental care project, also funded by Smart Start and operated by the Buncombe County Health Center, has conducted dental screenings and education on preventive dental care at MACFC.
- **Private Sector Grants.** Buncombe County Smart Start also supplies child care providers with opportunities to apply for private sector grants. Through this initiative, MACFC received grants totaling \$50,000 from an area bank in 2001.
- **Special Needs Assistance Program (SNAP).** With funding from Smart Start, BCCCS provides child care providers serving children with special needs with funds to purchase adaptive equipment and hire additional staff, as well as on-site consultation for teachers.
- **Child Care Quality Enhancement Project.** This initiative provides on-site training and technical assistance to child care providers.

Successes of MACFC

Through the efforts of concerned community members, MACFC has succeeded in its goal of building broad community support for a high-quality child care center. In addition to community collaboration, MACFC has enjoyed successes in increasing access to high-quality infant-toddler care.

Increasing access to care. The fundamental achievement of increasing access has been a critically important outcome for the center. When it opened, MACFC provided a brand

new good-quality child care option accessible to families living in the rural part of Buncombe County, specifically targeting families with low incomes and children with special needs.

In fall 2001, the organization was awarded an Early Head Start grant and planned to begin enrolling families in fall 2002. At the time of the site visit, the organization was also in the process of developing two satellite centers that, like MACFC, would be located in underserved rural areas of the county. Half the families at these centers would be privately paying, and the other half would be comprised of participants in Early Head Start or other families with low incomes. One of these new locations focuses especially on providing services to Spanish-speaking families—an area of great need in the community. Since the site visit was completed, this location began a recruitment effort to reach out to the area's Hispanic population. The results

thus far have been positive: Currently, more than half the members of an Early Head Start expectant mothers' group are Hispanic. MACFC has also recently established a site in a newly built YMCA facility. In addition to receiving services there, families may access the entire facility—gym, equipment, etc. The center manager of this site is male, and is developing an outreach strategy for fathers. Although still in the planning stages, these efforts might include father-child exercise or work-out sessions, weight programs, and other activities.

Increasing the quality of care. The board and staff of MACFC also have made a firm commitment to invest the resources necessary for providing high-quality care. For example, the center maintains low child-teacher ratios, has a management team of specialists to support the teachers, and supports teachers in their ongoing professional development.

During MACFC's development phase, the board was able to effectively articulate the importance of high-quality child care to the Buncombe County community and obtain support for the center from community members, civic organizations, churches, business, service agencies, schools, and foundations. Since opening the center in January 2001, the board and program staff members continue to bring groups to visit the center and showcase its facilities and services. The center also works closely with local higher education institutions to further its goal of enhancing community collaboration by providing hands-on learning experiences for education and nursing students.

Challenges of MACFC

The cost of quality. High-quality services, competitive salaries and benefits, state-of-the-art facilities: All of these

Child care providers serving children with special needs are given funds to purchase adaptive equipment and hire additional staff, as well as on-site consultation for teachers.

are expensive. Though MACFC's board and staff are committed to high quality standards (such as hiring skilled teachers and maintaining low child-teacher ratios), these also drive up costs. The reality is that the cost of infant-toddler care exceeds even the fees charged to privately paying families. In addition, the state child care subsidy does not provide adequate funding to meet the needs of families with low incomes who need child care. The waiting list for state child care subsidies is long, and reimbursement rates are low compared to the cost of providing care. In response, MACFC has provided scholarships to some families with low incomes while they wait for a child care subsidy, and must use private funds to cover the difference between the subsidy rates and the actual cost of care. As a result, ongoing fundraising remains both a necessity and a challenge for the organization.

Transitions from planning to operations. The second area of challenge for MACFC has been the transition from planning to operating a child care center. Since the center opened, board members have become less involved in day-to-day decision making. Because the board was so actively involved in making decisions about the center during its planning phase, it took time to realign roles and redirect their efforts to setting policy and supporting staff.

Thinking about expansion plans. Making decisions about expanding and adding satellite centers also has been challenging. Some staff and board members feel a sense of urgency to serve more children, while others want to be cautious about expanding too rapidly. There has been agreement among both staff and board members that any expansion that does take place must be handled very carefully to ensure that high quality standards are maintained.

Lessons Learned from MACFC

Rallying and maintaining community support. Securing community support and establishing relationships with community partners has been integral to MACFC's successes. In the early stages of the center's development, board members invested substantial time and effort in meeting with all significant child-family service providers in the community to share their vision for the center and build support for their plans. They also gave many presentations in the community to a broad range of groups and organizations. When they began a capital campaign, board members were able to call on key community stakeholders to accompany them on visits to foundations and donors, write letters of support, and provide public endorsement for their project. Since MACFC opened, it has opened its

doors as a training site for early childhood education students and professionals. Through all of these activities, MACFC has continued to garner the public and philanthropic support necessary for sustaining its mission and supporting its expansion plans.

Blending funding streams. Mountain Area Child and Family Center also has been successful in blending funds from a wide range of both public and private sources to support its vision of providing high-quality services. These sources have included foundation grants, private donations, child care subsidies, Early Head Start, and state grant funds from North Carolina's Smart Start initiative.

Seeking out experts. Obtaining the advice of experts at key points in the planning process also was essential to the project's success. For example, the board hired a fundraising firm to conduct a feasibility study and to design a fundraising strategy before launching their capital campaign. They also hired design consultants to develop designs for the center and outdoor play areas. In addition, they hired experienced staff. The executive director and key management team members have substantial previous experience in early childhood education, many of them in Head Start programs. This experience enabled them to get the center up and running quickly, supported the center's goal of providing high-quality and developmentally appropriate care, and allowed leaders to begin working towards expansion.

Conclusion

Though unique in history and structure, the MACFC experience underlies the importance of: community collaboration, the ability to blend funding streams, and the role of experienced staff in developing a high-quality child care program. MACFC also illustrates the crucial role that a clear vision plays in supporting organizational success. Established by a group of community members concerned about the county's unmet need for good-quality child care, the MACFC has made good on its vision of offering a diverse group of children the opportunity to experience nurturing, stimulating, and developmentally appropriate care regardless of their families' income level. ♣

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At MACFC, the cost of infant-toddler care exceeds even the fees charged to privately paying families. Ongoing fundraising to meet the actual cost of care is a necessity.



PHOTO: JANET BROWN MCCracken

PARENT PERSPECTIVES

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An important component of the ZERO TO THREE/Mathematica research effort (Paulsell, Nogales, & Cohen, in press) included focus groups with parents with low incomes from each of the case study communities. These discussions focused on parents' experiences in finding and using child care for their infants and toddlers. Thirty-one parents participated in each of 4 groups—9 in Colorado, 11 in Kansas, 9 in Missouri, and 2 in North Carolina. In 3 of the 4 groups, a total of 8 fathers participated; teenage mothers also attended at several sites.

Parents were recruited to participate by staff members in the four programs profiled in the research; many were enrolled in Early Head Start. All parents in the focus groups had infants or toddlers enrolled in the initiatives and were generally pleased with the care their children were receiving. The sections that follow present the barriers that parents described to arranging care, the characteristics of child care providers and settings that parents associated with high-quality care, and parents' recommendations for making good-quality infant-toddler care more accessible to families with low incomes.

Barriers to Accessing Good-Quality Infant-Toddler Care

The three main barriers parents identified were the inadequate supply of infant-toddler slots, the high cost of care, and the inadequate quality of arrangements they could afford.

Inadequate Supply of Infant-toddler Slots

Before securing their current child care arrangements, most parents in the focus groups said they struggled to find an infant-toddler slot for their child. According to parents, none of the four communities offered families with low incomes an adequate supply of quality child care for children under age 3.

Parents identified several circumstances that further complicated the task of arranging infant-toddler child care. For example, parents in Colorado Springs, Colorado, and Sedalia, Missouri, reported having difficulty finding providers who would accept state child care subsidies; many accepted only direct payments for care and charged fees that were higher than the subsidy reimbursement

at a glance

- Inadequate supply, high cost, and inadequate quality of affordable arrangements are parents' chief child care concerns.
- Parents want a child care setting that is warm, cheerful, calm, and inviting.
- Parents feel that caregivers' wages should be increased.
- Knowing their child is loved in their absence is most important to parents.

rates. A handful of parents noted that finding openings for multiple children of different ages could be particularly difficult, especially when one child was an infant or toddler. Parents in some communities reported that affordable care during nonstandard hours, such as evenings and weekends, was almost nonexistent.

Across all sites, parents reported that waiting lists for infant-toddler slots were the norm. Waiting time on these lists ranged from about 3 months in Kansas City, Kansas, to as long as 15 months in Colorado Springs. While they waited for a slot to open up, parents said they relied on family members or other informal providers.

In addition, many parents felt there was a mismatch between the type of care they wanted for their infants and toddlers and the types of infant-toddler care available in their communities. According to parents, most infant-toddler slots were offered by family child care providers, both regulated and unregulated. Some parents in the focus groups used and were satisfied with their family child care arrangements. Many, however, expressed a preference for center-based care, because they believed centers maintained higher standards of quality and were monitored more regularly.

We tried to get [child care with] state pay [subsidies], but no one was taking any more state pay babies at that time. We called everyone, and they were like, "Try program so and so, maybe they can help you." Everyone just said they could put us on a waiting list. Early Head Start finally helped us get a spot.

The High Cost of Infant-toddler Care

In all four sites, parents said that infant-toddler care in their communities was very expensive. According to parents, market rates for good-quality infant-toddler child care were out of reach for families in with low incomes their communities. In Kansas City, one father declared,

It makes no sense for you to work when you have to turn around and turn over your whole check to them. Good quality infant-toddler care is \$160 a week at least, even \$200. Any person who does not have a regular job would not be able to afford that. They won't be able to work either. If you work, you'd have to give them your check.

Related to affordability, some parents in Colorado Springs said that they could not accept salary increases for fear of exceeding income limits and losing their child care subsidies. Similarly, in Buncombe County, North Carolina, one parent suggested that the state reassess subsidy eligibility limits so that parents like her would not feel "trapped" at their income level because of fear of losing their child care subsidy.

If it wasn't for state pay or the Early Head Start program, there would be no sense in going to work, because there would be no paycheck. Ninety dollars a week for one kid, just for a toddler! I had two toddlers, and I want to say it was \$150, 160 a week just for those two. Without state pay I could forget it. I might as well be a stay-at-home mom. It is expensive, very expensive.

Inadequate Quality

Focus group participants also discussed their views about the quality of infant-toddler care accessible to families with low incomes in their communities. Their observations were based primarily on child care arrangements they used or facilities they visited before finding their current arrangements through the case study initiatives. Parents in several communities cited large group sizes and inadequate child-teacher ratios as indicators of poor quality. One parent compared her child's current provider to others in the community:

The ratios in other places are so much. I mean, there are so many kids to one person, to a point where there is no way that I myself could keep an eye on that many children at that age. How can anybody else?

In addition, many parents cited a low level of interaction between providers and children as a sign of poor-quality care. For example, a mother in Missouri remarked, "Every day when I got there, they had her asleep in a swing, with a bottle propped in her mouth." Several parents described caregivers who appeared to ignore the children and instead had personal conversations among themselves.

Parents also said that they and their children were not made to feel welcome in previous child care settings or during visits to prospective child care providers. For example, one parent said, "A lot of the day cares I went to, you walk into a place and you expect someone to tell you 'Hi,' you know, to say 'Hello, welcome.' You didn't get nothing; they looked at you like, 'Oh, another baby.'" Other parents cited their children's unhappiness about going to child care and their eagerness to leave at the end of the day as signs that their children did not feel welcome and were not well cared for.

Several parents told stories about the use of inappropriate disciplinary techniques or overly restrictive practices. One parent, whose son had a problem with biting as a toddler, said that a caregiver threatened to bite her child in an attempt to stop him from biting. In Sedalia, a mother described what she considered to be an overly restrictive environment in their child's toddler classroom,

At my old day care, I felt like every time I would go in there it was time to put the toys up, and I felt like, "When do they

"No one was taking any more state pay babies. . . Everyone just said they could put us on a waiting list."

play?" Every time I'd go in there . . . she'd be yelling at them, and if they took a toy off the shelf she'd yell at them to put it back and sit on the line.

Health and safety practices were also of concern to parents. Parents expressed concern about accidents and unexplained bumps and bruises. Cleanliness was also a major issue for many parents. Several commented that in some child care settings their children were not kept as clean as they should be; they had dirty clothes and faces at the end of the day and their noses were not wiped when they had colds. Others told stories about the lack of adequate processes to safeguard health.

Parents' Opinions About Quality

During the focus groups, parents talked about their own definitions of quality child care and the key elements of what they thought would constitute a good-quality child care setting. Often, parents described positive aspects of the child care settings they were currently using. Not surprisingly, these items correspond with many characteristics of child care settings that early education experts think are indicators of quality. The following section describes the characteristics of infant-toddler child care settings that parents said were important.

Welcoming Environment

Parents described an ideal child care setting as one that was warm, cheerful, calm, and inviting for both children and parents. A father in Colorado Springs felt that teachers at the center his child attended were like members of his extended family; other parents voiced similar feelings about their children's caregivers. Some parents described the relief of seeing that their children were happy and emotionally close to their caregivers; a few even said their toddlers called their teachers "Mom."

My son, he loves to go to school. If one day I can't take him to school or something, he will get mad at me. He says, "No Mama, I want to go to school, I have to go to school." We had spring break and all he talked about was going to school, but I'm like, "Honey, there's nobody at school." So it was pretty funny, he really wanted to go to school, and I knew he enjoyed his class.

Quality Interactions Between Caregivers and Children

During the discussions, parents overwhelmingly associated good-quality care with individualized attention provided to their children from enthusiastic, professional, and personable caregivers. They expected providers to become familiar with the children's personalities and the

specific likes and dislikes of each child. Parents in Kansas praised the care and attention their children received in the infant room at a particular center because the teacher constantly talked with the infants, even those who were only a few months old. About this teacher, one parent said, "I've never seen a lady that talks so much. Any time she touches them, she's talking. She talks to them the whole time she's caring for them. . . . She greets them and tells them what we are getting ready to do, like 'we are going to go and change your diaper.'" Finally, some parents noted that continuity of care was important for ensuring quality interactions. Parents recognized the importance of low staff turnover and maintenance of predictable routines for their children.

Kids see the same faces, are greeted by the same receptionist, and it's that stabilizing factor which I think we all need, especially children, because they need to know what they can count on.

Developmentally Appropriate Activities

Parents also emphasized the importance of stimulating, age-appropriate activities for their children in an environment of learning, not merely a place where they "are just stuck in a play pen." Participants from all the focus groups likened the child care settings to school.

Several parents who used family child care homes emphasized that even though their children were cared for in a home, they also received developmentally appropriate educational activities. For example, one mother said that she valued the combination of a more intimate home setting for her child and stimulating educational activities.

It is important for him to learn things, and he has just learned so much. I wish everyone had a place like this where they could take their children. It's just a big relief to know . . . that I can go to work and focus on my work. And I know that he is having a blast here.

Health and Safety Practices

All focus group participants stressed that child care facilities should be clean, and that providers should meet the highest standards for health and safety, including offering healthy meals. Not only should the area be spacious and clean, with minimal clutter, but the children should have a clean appearance. Parents also stressed that they wanted assurance from providers that procedures were in place to prevent injuries. Many said that they liked the hand-washing and tooth-brushing routines implemented in their children's child care settings. Finally, parents with children

"Kids see the same faces, are greeted by the same receptionist, and it's that stabilizing factor which [children need] because they need to know what they can count on."

in Early Head Start felt reassured that program staff visited child care partners regularly to work on quality improvement and ensure that health and safety standards were met.

Good Communication and Feedback

Open, honest communication between parents and providers was critical for focus group participants. Parents appreciated receiving daily updates from child care providers, daily record sheets that summarized children's eating and sleeping patterns, calendars of upcoming classroom activities, and parent-teacher conferences. Parents also appreciated information caregivers provided about their children's achievements and developmental milestones. For example, one mother described how her family child care provider took digital pictures of activities so that she could see what her daughter did while she was at work.

Parents were especially pleased whenever providers took the initiative to ask questions about their children, such as "How do you feel her speech is going?" or "Do you think maybe you should have the pediatrician examine that?" Parents also said they expected to receive accident reports if their children had falls or other accidents. Careful monitoring and follow-up regarding the child's development and well-being demonstrated to parents that caregivers were involved with their children and cared about them.

Parents wanted opportunities to express concerns and appreciated providers who were open and receptive to these discussions. Other parents said child care providers must allow parents to visit freely without giving prior notice; they appreciated caregivers who welcomed them to observe classrooms and participate in activities.

Capacity to Care for Children With Special Needs

Parents of children with special needs emphasized the importance of finding a child care setting that could address their children's needs effectively. Some focus group participants had children enrolled in early intervention services; others had children with special health or emotional needs. Child care providers used by some participants collaborated with early intervention service providers to coordinate services for the children in the child care setting. For example, one mother expressed her appreciation for a child care provider who accommodated her son's asthma treatments:

He had to have a breathing treatment every hour. I was willing to stay home with him, but they were like no, bring him. They gave him all the attention he needed, plus they attended to the other children. . . . I don't know if I could have done that for someone else's child. I mean, really, it takes a lot.

Suggestions For Change

Focus group participants were generally satisfied with their child care arrangements, although they offered several recommendations for improving access to good-quality infant-toddler care. In every focus group, parents emphasized the need to increase funding for child care—to make it more affordable and accessible to families with low incomes and to improve quality. In particular, some parents felt that the wages of caregivers should be increased to reduce staff turnover and to motivate them to do their best for the children. Several parents suggested increasing income eligibility limits for child care subsidies so that more working families could qualify for assistance. Finally, some parents said that providers should be encouraged to offer care during nonstandard hours, such as evenings and week-

ends, and that child care centers should have "sickrooms" where ill children could be cared for so that parents did not have to miss work.

Summary

Parents with low incomes value the same things in infant-toddler child care that child development professionals do: warm, stable relationships with caregivers; attention to health and safety; and an environment that promotes growth in all areas of development. Unfortunately, families with low incomes can seldom find such care at a price they can afford, even with child care subsidies. When community partnerships are able to combine resources and offer high-quality care to families with low incomes who have infants and toddlers, the families recognize, value, and make good use of the opportunity they are given. Time after time, parents in the focus groups emphasized that knowing their child was loved in their absence—his needs met, her cries answered—made the transition to child care easier for everyone. Equally important, confidence in one's child care provider allows working parents to shift their focus, be truly productive, and concentrate fully on their other jobs. ♣

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One mother described how her family child care provider took digital pictures so that she could see what her daughter did while she was at work.



TIME TO CARE: Redesigning Child Care

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PHOTO: JANET BROWN MCCrackEN

The following excerpts from *Time To Care: Redesigning Child Care To Promote Education, Support Families, and Build Communities*, published in 2003, are reprinted with the permission of The Century Foundation. To order online, visit <http://www.tcf.org/Publications/>.

There are almost 12 million infants and toddlers in the United States. According to the National Survey of American Families, more than 6 million children under age 3 spend time in child care on a regular basis (Urban Institute, 2001). This trend has had important repercussions on the first 3 years of life; says a recent National Research Council report, *From Neurons to Neighborhoods: The Science of Early Childhood Development*, "second only to the immediate family, child care is the context in which early childhood unfolds, starting in infancy" (Shonkoff & Phillips, 2000, p. 297). Yet the quality of care available to very young children in the United States is far from adequate.

It is time to redesign child care. From decades of research and practice, we know many ways to enhance the child care experience so that it will support the healthy development of infants and toddlers. Seven principles can guide parents, program leaders, and policymakers in shaping this new image of child care.

1. **Child care is an opportunity.** The reality is that

children in the United States spend many hours in out-of-home settings. The argument for investing is straightforward. It is just plain common sense to take advantage of the opportunity that child care provides to promote education and to reach out to parents.

2. **Regardless of the age of the child and the setting, child care is not exclusively a "home" or a "school."** Child care is a "third setting" that has value in and of itself. Because children spend long hours in care, it must reflect the comfort of home, yet it must include experiences to promote education. The educational

at a glance

- More than 6 million children under 3 in the US spend time in child care on a regular basis.
- Seven principles can guide a redesigning of child care.
- Standards and enforcement, training and compensation, and an infrastructure of support improved the quality of military child care.

experiences that children have in child care are not a substitute for school, but rather should complement and support the entrance into school or the regular school day. The goal of education in child care should be broadly defined, reflecting a developmental approach to learning that integrates the physical, social, emotional, and cognitive development of children at each stage of their lives.

3. Child care for young children is not the same as child care for school-age children.

Like the little red schoolhouse, the term child care has been used to refer to services for children from birth through early adolescence. In the new era, we need to differentiate our image of child care for younger children from that for school-age children, because planning, staffing, and oversight differ among these developmental stages.

4. The heart of any good child care program is the relationship between the children and the provider, and the relationship between the parents and the provider.

For young children as well as school-age children, child care must include supportive adults who help guide and mentor children while they learn. Providers themselves must be supported with adequate working conditions so that they in turn have the resources to nurture the development of children and support the family.

5. Child care is not an isolated service for children; rather it should be seen as a hub of support for families. Child care providers cannot work in isolation from the families they serve nor from the communities where they live. Instead, child care can serve as a doorway for delivery of a range of services that families need. In addition, child care must reflect the diverse needs of families, which means that a range of good choices must be offered.

6. Child care is not a private responsibility, but must be a public service. Like any public utility, child care requires public financing to provide access to all families. It cannot continue to be funded by parents alone or financed on the backs of child care providers. We need an infusion of public support to make it work.

7. Because child care supports children and families, it is everyone's business to get involved. Child care is a community-building endeavor that can help promote

greater civic engagement and create stronger links between cultures and across the generations.

Putting these principles into practice is never easy. Yet with adequate resources and a strategic plan, even a failed child care system can be redesigned to promote education, support families, and build communities. Corporate, community, and state child care systems have much to learn from the experience of the United States military, which transformed its child care system to reflect three essential ingredients of quality care: standards and enforcement, training and compensation, and an infrastructure of support.

The Department of Defense (DOD) child care system is the largest employer-sponsored child care program in the world, serving more than 200,000 children from birth to age 12 daily at more than 300 locations worldwide. Known as the Child Development Program, in 2000 it included more than 800 child development centers and

more than 9000 family child care homes.

In the 1980s, the U.S. military child care system suffered from a series of problems similar to those currently reflected in civilian life. Tens of thousands of children were on waiting lists, facilities often were unsuitable, there were no comprehensive standards or a rigorous inspection system, and, most notably, caregivers lacked training and were poorly paid, earning less than the people who stocked the commissary.

Then the situation changed dramatically. Spurred by a series of reports and congressional hearings, Congress enacted the Military Child Care Act of 1989, mandating improvements in military child care. In the same year, the DOD inspector general made 53 recommendations for improving the program. The military took action, putting in place a comprehensive improvement plan to provide high-quality affordable care. Nearly 10 years later, a study conducted by the Rand National Defense Research Institute examined the implementation and outcomes of the military efforts and found significant improvements. The military has important lessons to share with the rest of the nation on how to improve the quality of child care for all children.

At least three essential ingredients have helped improve the quality of the military child care system: standards and enforcement, training and compensation, and an infrastructure of support.

Standards and enforcement: A critical element of the effort to improve the quality of child care programs was the adoption of a set of measures to hold child care providers accountable. DOD established uniform certification standards that all the child development centers and

The Department of Defense (DOD) child care system is the largest employer-sponsored child care program in the world, serving more than 200,000 children from birth to age 12 daily at more than 300 locations worldwide.

family child care homes were required to meet. Next they developed mechanisms to determine whether these standards were in fact met and enforced sanctions for failure to meet them. The enforcement process includes unannounced visits at least four times a year. Standards established by DOD govern facility requirements, staff-child ratios, staff training and qualifications, child-abuse prevention procedures, funding, parent participation, and health and sanitation. Third, the military required that programs go through a national accreditation system. Along with improving standards, DOD increased staff training and compensation. One of the main reasons the military was able to implement these changes was the increased use of appropriated dollars that helped keep programs affordable to families while improving quality. DOD implemented a comprehensive training program. New hires working in centers, family child care homes, and school-age programs are required to undergo an orientation before they work with children. The orientation includes such topics as child-abuse identification and reporting, first aid and CPR, health and sanitation procedures, and parent and family relations. Once they begin work, center and family child care providers must complete 15 competency-based training modules within 2 years of being hired. Furthermore, all staff must participate in 24 hours of training annually.

Training and compensation: The training system is tied to improved wages and promotions. DOD requires that center caregivers complete all training modules in order to remain employed and to receive the highest hourly wages available to DOD caregivers. Both full- and part-time staff receive life insurance, health insurance, sick leave, and retirement benefits, generally providing an additional value equal to 22% of their salaries. The military wage policy increased incentives to complete training, improved wages, and reduced turnover. Staff turnover, which had been as high as 300% at some bases, in 2000 was below 30% annually.

Infrastructure of support: The military Child Development Program includes an infrastructure of support for its programs, including a "single point of entry" (or a primary contact) at each installation. Although its exact location may vary across the services, this single point of entry helps bring cohesion, information, and support to the programs. For example, DOD is required by law to ensure that every child development center employs a training and curriculum specialist who is a professionally qualified early-childhood educator. Furthermore, family child care providers benefit from being part of a network that provides ongoing training, visits, and support. The single point of entry helps bring together these resources for the individual programs.

Final Reflections

I wonder what child care will be like when my own grandchildren arrive. I hope that all new parents have more time, less stress, and a system of services to help them build stronger families and caring communities. I hope that when my grandchildren enter child care, they will spend their days in beautiful spaces with caring, smart, well-supported, and creative providers. I hope that their teachers will be valued and respected by their community and that they will have warm, friendly, and productive relationships with the children and families they serve. More than anything, I hope that someday we will be able to claim that the United States is doing the very best for all of our children, particularly the most vulnerable. The door is open for all of us to redesign child care. Like the children in child care themselves, we do not have a moment to waste.

**When my grandchildren arrive,
I hope that all new parents
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PROMOTING MENTAL HEALTH IN CHILD CARE SETTINGS:

Caring for the Whole Child

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PHOTO: JANET BROWN MCCrackEN

More than ever before, child care providers are being asked to promote and protect the healthy social and emotional development of children. In the same vein, early childhood mental health services pursue many of the same goals as child care providers in fostering children's mental health: promoting the overall emotional and behavioral well-being of children, helping them develop healthy peer relationships and caregiver attachments, strengthening child care staff's competencies in managing challenging behaviors, and identifying needed services for children with more serious mental health problems. But neither group of providers acting alone can be successful in comprehensively understanding the needs of the children or their families nor in delivering the spectrum of services that are needed to do this. It is only when the child care and mental health systems are closely aligned that children and families can be better served to this end.

Linking Child Care and Mental Health Services

The goal of forging child care and mental health partnerships at the State and community levels, though widely accepted as worthy, continues to prove challenging. The mental health community has identified the following obstacles to providing children with the mental health services they require: great disparities in service coordination, limited access to services, and gaps in provider expertise (U.S. Public Health Service, 2000). The creation of child care and mental health partnerships has been highlighted as an essential action step to support the provision of early childhood mental health services (Child Care Bureau, 2002).

Understanding Very Young Children's Social-Emotional Needs

All children benefit from healthy social and emotional development and all caregivers and parents benefit from developmentally appropriate support and guidance in this

area. For children with significant mental health problems, coordinated services are even more important (although research on the incidence of such impairments is still fragmentary). An estimated 1 in 10 children and adolescents suffer from mental illness severe enough to result in impairment (Burns, et al., 1995). In some early childhood settings (e.g., some Head Start and child care programs), as many as 4 out of 10 preschoolers exhibit one or more problem behaviors, such as aggression, according to teacher reports (Kupersmidt, Bryant, and Willoughby, 2000).

As the number of children in care steadily grows, more and more service providers, mental health agencies included, are seeing the need to serve children where they spend the bulk of their day—in child care. This linking of services offers benefits to children, who receive more responsive care and treatment; to parents, who reap the benefits of coordinated case management; and to child care and mental health providers, who better understand the needs of the children with whom they work.

The question of how best to coordinate services persists, however. Here, we outline the ways in which child care providers can partner with parents and mental health professionals to respond to the continuum of children's mental health needs. These are steps that can be taken by high-quality child care programs, extending the scope of their past and ongoing efforts. This discussion also highlights approaches that all child care providers can undertake, even if they have not in the past been fully successful in their attempts to give priority to children's social and emotional development.

Key Elements of Effective Services

Because every child care setting is unique, and community and State contexts differ greatly in the availability and nature of resources and the priority given children's mental health, there can be no standard recipe for success. There are many workable approaches for addressing children's behavioral and emotional development. It is possible, nevertheless, to identify the key elements that are applicable to

the delivery of effective mental health services in most child care settings.

The key elements of effective services include:

- ability to identify the principal stakeholders and partners in responding to children's mental health needs;
- access to a mental health consultant to support the caregiver(s) in the classroom or family child care provider home;
- individualization of services;
- screening and assessment;
- diagnosis and in-depth services for children with disabilities, including clinical services for children and families with serious mental health impairments;
- family-centered services (e.g., cultural and linguistic diversity) delivered by child care and mental health providers working together;
- training and professional development of child care staff to enable them to better recognize and respond to children's social and emotional development;
- training and professional development of mental health professionals to help them understand how to add value in the child care setting; and
- "know-how" to mobilize resources to support program services that respond to the full spectrum of children's mental health needs.

Following, we will examine each of these key elements in depth, highlighting the important contribution each makes to the coordinated delivery of mental health services within the context of child care.

Identifying Stakeholders and Partners

Three central partners are critical in promoting mental health in child care settings:

- parents,
- child care providers who are striving to attain and/or sustain high standards of quality, and
- mental health organizations and individuals.

The overriding importance of family caregiving on child outcomes, and the resulting need for child care to complement and constructively extend the efforts of parents in the home, goes without saying. Parents are children's first teachers and have the most direct and lasting impact on the trajectory of children's lives. The daily, ongoing activities and relationships built by other caregivers in a child's life must always include and build on the foundation of a child's relationship with his or her parents.

The contribution of high-quality child care to children's overall development and, in particular, to sound social and emotional development and mental health, is well-documented and widely accepted by researchers, providers, and policymakers. Similarly, it is recognized that programs of

at a glance

- Mental health service providers see the need to serve children where they spend the bulk of their day—in child care.
- Nine elements have been identified that characterize delivery of effective mental health services in child care settings.
- Early childhood mental health consultation is the primary partnership strategy for bringing together the child care and mental health communities.

mediocre or low quality may have a neutral or, in extreme instances, a negative impact on development and social-emotional competence. Research is still underway on the precise ingredients of quality care and its prevalence, but there is general agreement that critical program variables include the hours of care; the stability and continuity of care; group size; child-staff ratios; and the skills of child care staff in relating to children and facilitating their growth, learning, socialization, and acquisition of such capacities as self-regulation. Paramount among these variables are the qualifications, training, and professional development of the child's caregivers, both in center-based and family child care home settings.

Although working toward quality child care and involving parents in the process are crucial to promoting children's mental health, they are not sufficient. Even quality child care programs lack the resources, and generally do not have sufficient in-house expertise to address the full gamut of the child's mental health needs. Child care providers must turn to partners in the mental health community in order to implement a three-fold strategy: promotion of social and emotional development and good mental health for all children, prevention and intervention to minimize and resolve mental health stressors, and treatment of identified mental health needs.

Access to a Mental Health Consultant

The primary partnership strategy for bringing together the child care and mental health communities is by accessing the services of an early childhood mental health consultation (Knitzer, 2001). This approach makes it possible to serve children in the child care setting where they spend most of their time when not at home. It involves a mental health professional (or trained paraprofessional operating with support of off-site professional supervision) coming into the child care center or family child care home from time to time.

Although mental health consultation to child care programs can take many forms, common approaches used by consultants often included the following:

- focusing on promotion of healthy social and emotional development for all children in the child care program, rather than simply addressing mental health problems of a few after they reach a crisis stage;
- acting as a resource to caregivers and parents to enhance their ability to support children's healthy social-emotional development;
- helping programs develop linkages with agencies and funding sources in order to leverage the program's ability to provide high-quality early childhood services;
- working in partnership with teachers and other child

care staff to observe children and advise on ways to stimulate the children's acquisition of social and behavioral competence as well as to promote early literacy and school readiness skills; and

- coaching caregivers in using techniques to head off problems before they occur (e.g., how to structure the child care environment, planning daily routines, and child management), using prevention to minimize the incidence of child-related problems.

Programs that incorporate these elements are able to weave together a more integrated and consultative approach in delivering a full menu of mental health services not only to the children,

but also to their parents and providers. The benefits to the program of using mental health consultants include:

- training and staff development for caregivers on social and emotional issues and on how to support children and families;
- family-centered services, including parent education, family counseling, and crisis intervention;
- timely intervention to avoid circumstances in which children with emotional and behavioral difficulties are asked to leave a child care program. This also helps to alleviate caregiver burnout, in which child care staff depart the program out of frustration at being unable to care for troubled children;
- timely on-site consultation to assist caregivers in spotting children who are prone to disruptive acts such as aggression, bullying, biting, or other more subtle emotional and behavioral problems, as may be seen in the withdrawn, depressed, or overly quiet child; and
- individualization of services, screening and assessment, and identification of children with serious problems who need in-depth diagnosis and treatment, including referral of those children who might benefit from clinical mental health services.

The early childhood mental health consultant model involves a close partnership between the consultant and caregivers in which each brings their special expertise to bear. The consultant can help train early childhood staff in promoting children's social and emotional development in a similar fashion to efforts underway to assist early care and education teachers in promoting children's acquisition of early literacy and school readiness skills (Phillips, 2002; White House, 2002).

The table below provides examples of the complementary and shared expertise of child care staff and the mental health consultant that can be harnessed to promote children's social

Even quality child care programs lack the resources, and generally do not have sufficient in-house expertise to address the full gamut of the child's mental health needs.

and behavioral competence. Both skill sets are equally important in identifying, assessing, and responding to the mental health needs of children in child care.

Individualization

Individualizing is a general precept of quality early care and education programs. This stems from the commonsense understanding that each child is unique, with an individual profile of strengths, abilities, and capacities, balanced by needs and vulnerabilities. Moreover, each child grows up in the context of a family with a home culture and language, and with its own goals, priorities, and expectations for the child's development and learning. Successful child care programs strive to tailor their intervention to these realities of child and family functioning and context.

Individualization complements and is an essential ingredient of the three-part strategy for child care-mental health partnerships, namely: promotion of social and emotional development for *all children*; prevention and intervention to alleviate stressors and minimize exposure of *all children* to harm; and treatment of identified needs for *selected children* with special needs and disabilities (Florida State University Center for Prevention and Early Intervention Policy, 2000, p. 52-53). Shonkoff and Phillips (2000) summarize the

evidence that supports the critical role of individualization in service delivery: "Extensive research from a variety of service system perspectives converges on the principle that effective intervention demands an individualized approach that matches well-defined goals to the specific needs and resources of the children and families who are served. Thus, there is scant support for a one-size-fits-all model of early childhood intervention" (p. 360).

In order to individualize services, child care staff need information about the child's functioning and developmental potential. This can come from *informal sources*, such as caregiver observations of the child in the child care setting, discussions with parents, and input of the mental health consultant's observations of the child. However, informal and anecdotal information must be supplemented by *formal sources*, such as screening and assessment and, for some children, in-depth diagnosis, clinical follow-up, or both.

Screening and Assessment

A generation ago, screening and assessment of children from birth to age 5 emphasized a one-dimensional focus on cognitive functioning and IQ testing. Today, most early childhood experts endorse a multi-dimensional approach that recognizes the interplay of multiple

CHILD CARE STAFF AND MENTAL HEALTH CONSULTANTS COMPLEMENT EACH OTHER'S EXPERTISE

Child Care Staff	Mental Health Consultant
• Ensure stable caregiving arrangements, small group sizes, and high caregiver-child ratios • Encourage children to do things for themselves and acknowledge their attempts (even if unsuccessful) • Create safe opportunities for children to experiment creatively with materials • Give children ample time to work with materials • Encourage children to physically explore the environment • Thank children • Provide children with reasons for rules or schedules • Be physically available to children • Make frequent eye contact with children • Talk to children at every opportunity • Pay close attention to children when they talk • Invite children to contribute their ideas • Respond promptly to infants' cries • Partner with parents to provide care that reflects children's individual schedules, as well as family values and culture • Give children choices • Get to know children as individuals • Tune in—and respond to—children's moods Adapted from: Brophy-Herb, 1997	• Understand typical and atypical child development • Understand young children's social and emotional development • Able to integrate mental health activities in group settings • Possess observation, listening, interviewing, and assessment skills • Be culturally competent • Understand adult learning principles • Be sensitive to community beliefs and strengths • Aware of treatment alternatives • Possess knowledge of family systems • Able to facilitate communication with, and among, staff • Understand external community systems serving children and families Adapted from: Cohen & Kaufmann, 2000

domains of the child's functioning.

As an example, the Head Start program has evolved a comprehensive strategy for screening and assessment based on the central concept of individualizing services (Head Start Bureau, 1998). Child assessment is designed to support a curriculum strategy for all children that is "... developmentally and linguistically appropriate and responds to each child's individual rate of development, interests, temperaments, languages, cultural backgrounds, and learning styles ... [and that] supports inclusion of children with disabilities, as described on their Individualized Family Service Plan (IFSP) or Individualized Education Program (IEP)."

Head Start's strategy (including Early Head Start) from birth to age 5 centers on four interrelated steps in *The Individualizing Cycle*:

- screening—developmental, sensory, and behavioral;
- evaluation (diagnostic testing and/or examination for observable, known, or suspected health, developmental, sensory, and/or behavioral problems); multidisciplinary team and individualized program/plan follow-up;
- planning for individual children; and
- ongoing assessment.

Although child care programs are not subject to the same performance standards and may fall short of Head Start funding levels, there are many resources available to them when they reach out to mental health agencies, schools, health agencies, and other community partners. Nationally available resources include Child FIND (operated through education agencies), which assesses children upon request; IDEA (generally operated through health agencies for infants and toddlers and education agencies for preschoolers), which can assist in screening, assessment, and in developing an IFSP or IEP; and the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program (generally operated through health agencies). In addition, many States and communities have their own program resources, operated through health and mental health agencies, schools, and other organizations, some of which include a focus on child care.

It should be kept in mind that screening and assessment is not "magic" and will not provide all the answers about a child. At its best, screening will raise a red flag and prompt a skilled observer to ask pertinent questions about how well (or poorly) the child is functioning in one or more domains and to follow up appropriately. Moreover, testing instruments do not function equally well for all children, and tend to be less satisfactory in addressing the diversity characteristic of child care programs that serve a high proportion of children whose families are poor, who are racial or ethnic minorities, and who may lack fluency in English. For these reasons, referrals for further diagnosis and, as necessary, in-depth services for children with disabilities, including clinical services for children with

serious mental health impairments, are a necessary follow-up to the screening and assessment processes.

Services for Children with Disabilities

While many children will exhibit behaviors along a continuum of normal to mildly disruptive, certain children will manifest more serious emotional and behavioral problems, whether from their own makeup or in reaction to inadequate nurturing and support from those around them. It is imperative that seriously troubled young children receive appropriate help, and child care providers can be the catalyst that ensures that budding problems are recognized and addressed.

Not all of the problems of children are easy to resolve. Problems do not necessarily start or end with the children themselves, but may stem from parents, caregivers, or other aspects of the child's environment. Parents who suffer from an illness that can disrupt parenting (e.g., maternal depression, anxiety disorders, bipolar disorders, alcoholism, or other substance abuse) put children at increased risk of aberrant behaviors, such as aggression, poor peer relations, depression, and serious psychopathology. Caregivers who lack early childhood training and skills can fail to properly structure the environment or implement a responsive, individualized curriculum, and thereby exacerbate or trigger adverse social and emotional behaviors of children in their care. In all cases, nevertheless, approaches to help these children and their families require that child care staff establish (directly or in concert with the mental health consultant) linkages with health, mental health, and other agencies that can diagnose disorders and provide the necessary special services, including clinical treatment, that children with disabilities and other difficulties require. Mental health therapies may focus on an individual child or, more commonly, involve the child and the family. Often, the child care staff can play a role in supporting actions to implement the IFSP that details the child's treatment plan.

In considering strategies to address the special circumstances of those children with severe problems in social and behavioral development, both mental health and early childhood scientific experts have provided some caveats. The Surgeon General's report on mental health, for example, underscores the shortcomings of existing systems to respond to the challenges of helping such children, citing the limitations of resources focused on children and the acute shortage of mental health personnel with the training and experience to serve children from birth to age 5 (U.S. Public Health Service, 2000). Echoing these concerns about limitations in the nation's ability to address children's social and emotional problems, Shonkoff and Phillips (2000, p. 123) state: "For children whose problems do not fall within the clinical range, early interventions to address regulatory behavior focused on 'fixing' the environment to reduce demands on the child warrant serious attention to balance the current focus on 'fixing' the child."

Family-Centered Services

To be successful in promoting healthy social and emotional behaviors among children from birth to age 5, actions of caregivers and mental health consultants must involve the family. The cornerstone of family-centered services is recognition of the primacy of the parental role in the child's growth and development. In this context, the role of parents should be interpreted broadly, and in some cases may be assumed by grandparents or other relatives (including siblings), by foster parents, or by noncustodial parents (typically fathers).

Many child care programs have already established close relationships with parents that provide a foundation for addressing mental health issues. Child care staff tend to be respectful of and knowledgeable about the family's community and cultural context. The values of treating parents with dignity, and dealing with them in a nonstigmatizing and nonjudgmental fashion, are widely shared in the early childhood arena.

Additional steps that child care and mental health providers can take to implement family-focused services include:

- empowering parents to define and achieve their goals for their own children;
- providing families with meaningful action options to pursue;
- helping parents eliminate poor parenting techniques and become more effective nurturers by providing them with information about how to enhance positive social and behavioral development and strengthen family competence;
- minimizing burdens and stressors on the family by identifying family priorities and problem areas and assisting parents to obtain needed services, including crisis intervention;
- bringing mental health services to the family, rather than the parents having to struggle to obtain the services; and
- encouraging child- and parent-focused interventions, including parent-child therapies, when needed.

Professional Development of Child Care Providers

Child care staff training and professional development has been recognized as an essential feature of a quality program. However, there is a severe shortage of early childhood professionals with mental health expertise (Phillips, 2002). In some States and communities, training that includes a special focus on social and emotional development has been given high priority, in a few cases with the collaboration and support of the mental health community.

Given the importance of the child's relationships with peers and adults to social and behavioral functioning, the skills and competence of teachers and other staff in organizing developmentally appropriate environments, structuring curricula, and orchestrating day-to-day activities is pivotal to program success. Thus, training to support children's

mental health must be an integral part of an overall strategy for refining staff abilities to work with children and their parents and to link with community partners.

A sound plan for professional development can enhance the capabilities of child care staff and improve program quality. It can also reduce staff burnout, minimize turnover, and enhance morale and job satisfaction—all steps that, over time, will enhance the quality of the child care experience for children. The following themes deserve special emphasis in any training and development activities:

- enhancing social and behavioral functioning to promote the child's current well-being and development, and support his or her future school achievement and life success;
- providing family-centered services, including how to communicate with parents about mental health issues;
- using and individualizing the results of screening and assessment;
- observing children and identifying warning signs in their behaviors suggesting the need for intervention.
- participating in developing the child's individualized plan (IFSP or IEP); and
- developing linkages with the mental health community and other partners (e.g., how to collaborate with the mental health consultant, seek out crisis intervention, identify funding and resources).

Professional Development of Mental Health Providers

There is a serious national shortage of mental health providers who focus on working with young children, with an acute lack of mental health professionals who are experienced in working in early care and education settings (U.S. Public Health Service, 2000; Shonkoff and Phillips, 2000; Knitzer, 2001). Across the country, however, there do exist program models that provide training to mental health professionals on partnering with child care providers.

One such model is the California Child Care Mental Health Project which addressed the need for qualified mental health staff by combining training of mental health and child care providers. The California Child Care Health Program, which also coordinates Healthy Child Care America activities, administered the project (not currently funded) and developed a replicable training curriculum for child care mental health consultation. The curriculum for training mental health professionals was designed to enable consultants to:

- understand early mental health and development;
- communicate with child care providers;
- ensure their ability to assess children in their play environments;
- counsel teachers on effective response to unacceptable behaviors and mental health interventions; and
- provide direct services where needed and on-site at child care facilities.

For more information on the California Child Care

Health Program, call 510-839-1195.

Programs like this one are important because the coordination of two systems starts with a relationship between two people. When the interactions between a mental health consultant and a child care professional are characterized by trust, warmth, and respect, there are opportunities for growth and learning in both individuals. Most important, good relationships between providers help to create a positive, supportive environment for all children, not just those receiving direct services. This dynamic allows the entire group to reap the benefits of a "classroom with good mental health" (Donahue, Falk, & Gersony Provet, 2000, p. 67).

Mobilization of Resources

Funding and other resources focused on young children's mental health are extremely limited and highly fragmented (U.S. Public Health Service, 2000; Knitzer, 2001). Hence, to be successful, community and State partnerships to support children's mental health need to be skillful at blending these disparate Federal/State public resources with local resources provided by foundations, businesses, and others with a stake in children's healthy social and emotional development.

Funding targeted explicitly on the identification and treatment of social and emotional disorders and disabilities in young children tends to be attached to individual children and is generally limited to private insurance (which covers a relatively small number of children and very few in subsidized child care programs) and public programs of which the most important are IDEA, Medicaid/EPST, State Children's Health Insurance Program (CHIP), and Supplemental Security Income (SSI under the Social Security Act).

Flexible resources that can be used to support child care-mental health partnerships generally do not focus on children's social and emotional development. These include the Child Care and Development Fund (CCDF), Head Start and Early Head Start, and Temporary Assistance to Needy Families (TANF). Additional sources of support include such groups as State and Regional Healthy Child Care America grantees (Reeves, 2001), supported by the Child Care Bureau and the Maternal and Child Health Bureau, and the Center on Children's Social and Emotional Competence, supported by the Child Care and Head Start Bureaus.

In general, funding mental health services for infants, toddlers, and their families requires persistence and creativity—whether it be in identifying opportunities for blending funding streams, ensuring appropriate screening and assessment, or formulating a plan for expanding community mental health services to very young children. Child care

and mental health professionals may be more successful in advocating together for the needs of very young children than they would be alone.

The benefits of child care and mental health partnerships are felt deeply by families who enjoy new access to the range of services they require, who can trust, learn from and grow within consistent relationships with providers, and who value the convenience of integrated services.

Summary

Coordination between child care and mental health providers, programs, and systems means better care for the whole child—and for his or her family. The benefits of child care and mental health partnerships are felt deeply by families who enjoy new access to the range of services they require, who can trust, learn from and grow within consistent relationships with

providers, and who value the convenience of integrated services. Promoting mental health in child care settings occurs most readily when services are co-located, when providers are cross-trained, and when staff members enjoy good relationships with one another, with consultants, and with families. ♦

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Music Can Be Instrumental in Helping Young Children With Special Needs To The Editor:

I recently read Lori Custodero's article, "The Musical Lives of Young Children," in the August 2002 *Zero to Three* Journal, which I received from my boss. As a music therapist who has worked with preschoolers with special needs for the past 8 years, I was fascinated by the contents of this article, and energized to respond!

So many of the points that Ms. Custodero made in her article are related to music therapy methods, interventions, and concepts, that I found myself writing notes in the margins of the article. It became an interactive reading experience! For example, she mentioned the similarity between the musical nature of conversations with babies and jazz musicians' improvisations. During my graduate training in music therapy at New York University, I learned how to apply the basic foundational elements of clinical improvisation, in which the music therapist and the client engage in synchronized music making. This can occur while sitting next to each other at the piano, or during musical exploration on guitars or on drums. The child discovers the common language of the emerging duet and begins to trust in the process. The "your turn/my turn" described in the article develops into reciprocal play and synchronized play based on the "mutual trust" which is fundamental for the "creative collaboration" that occurs.

Most of the developing communicative experiences mentioned in Ms. Custodero's article (pages 6 and 7) are focused on as actual goals during music therapy sessions with individual clients and with groups. For example, the music therapist may focus on helping a child with special needs (or group of children) to increase their awareness of themselves and others, to improve impulse control by becoming aware of sound versus space and the musical dynamics of creating loud vs. soft, fast vs. slow, gradations of volume levels, how to start and stop playing an instrument when cued, and how to independently prepare to start and prepare to stop by anticipating changes and cadences in the music. Most preschoolers with special needs, including children with autism, are capable of accomplishing these goals!

A very important music therapy goal for preschool children is to become less resistant to and more accepting of the transitions that occur throughout the school day. As Ms. Custodero explains, music can be instrumental (pun intended!) in reaching this goal since children "often use music as a transitional object that offers the comfort of the familiar in strange settings," in order to "bring close that...significant person or place...that is absent."

The article also mentions that the multi-sensory capacity of music (we can see, hear and touch a musical instrument; we can "feel" and hear our voices as we sing) "provides children with a variety of entry points into aesthetic, sensory and cognitive

challenges." As a music therapist, I support and expand upon the sensory integration goals of occupational therapists working with young children with sensory modulation and/or sensory discrimination disorders. These are the children who are tactile defensive, or who cover their ears when the sensory stimulation in the environment becomes overstimulating for them. Once again, the dynamics of music and sound can be adjusted in incremental volume levels and tempos in order to help the child to adapt and accept his environment.

Finally, Ms. Custodero observes (page 6) that "word rhythms replace the more freely articulated musical babbling" as a baby learns spoken language. The phrase "word rhythms" reminded me of melodic intonation therapy that many speech therapists and music therapists use with toddlers whose speech is delayed. Melodic intonation therapy focuses on the similarities between speech and rhythmic chanting or singing in order to help the child (or adult) to overcome his language delays or disabilities.

I look forward to learning more about research in this area, and would welcome responses from other readers who have had similar musical experiences with young children.

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VIDEOTAPES

Relationship-Based Child Care for Babies and Toddlers: A Video Training Series. (2002)

Produced by Gowrie Adelaide Productions at the Lady Gowrie

Center, Adelaide, Australia. Purchase \$90 each tape, \$310 for the series plus shipping and handling. Available from Child Development Media, Inc., 5632 Van Nuys Blvd., Suite 286, Van Nuys, CA 91401;

800-405-8942, fax 818-994-0153, www.ChildDevelopmentMedia.com. Manuals included.

This four-tape series portrays the theory and practice of relationship-based child care for babies and toddlers.

Priority is given to the relationships between caregiver and child and between caregiver and family. Fundamental to this model is a primary caregiving system that promotes secure attachment, a positive self-concept, and a sense of identity. As babies grow, their emerging sense of independence and autonomy is recognized and they are encouraged to do things for themselves and to experience success. Accompanying manuals include complete scripts, recommended reading, discussion questions, and references.

Primary Caregiving: Working Towards Secure Attachments In Children.

19 min. This video illustrates the significance of a primary caregiving system for babies and toddlers and their parents. The primary caregiver looks after the child's needs, taking a key role in feeding, sleeping, changing, and playing with the child. Attachment is considered so important that in the first weeks of the child's attendance the staff will often program and plan only for attachment. Only after the staff feel that a child is securely attached to his primary caregiver will they begin to plan for other areas of development, although attachment always remains a priority and is constantly considered and monitored. Practical considerations of primary caregiving are demonstrated and viewers gain an insight into how this system works within the normal operations of a busy baby room.

Secure Attachments: The Foundation of Relationships in Child Care Programs.

21 min. This video is designed to provide understanding of the theory of attachment and how it can be achieved with infants and toddlers in child care. Components of a secure attachment relationship are outlined. Behavior that suggests insecure attachment is also identified. The video is useful for communicating to parents the importance of attachment

relationships, behavior that supports secure attachment, and the role of the professional caregiver.

Parent Partnerships: Parents and Caregivers Together.

26 min. This video focuses on the importance of a high-quality relationship between the caregiver and the parent in achieving optimal outcomes for children in child care settings. As stated in the Lady Gowrie Children's Program, "the families of the children in our care can expect us to acknowledge that they are the primary carers of their child and the most important influence in their child's life." In the video the benefits of such a relationship are clearly demonstrated and the factors that make up the relationship are examined in detail.

Play That's Real: Fostering a Sense of Identity in Toddler Programs.

27 min. This video examines how caregivers can promote play that is meaningful for toddlers by building on everyday experiences and routines in the child care setting. It explores the significance of the caregiver-child attachment relationship as a basis for planning and learning. When toddlers are securely attached to their caregivers they are free to explore and take risks knowing that their caregiver is there for them. They enjoy a safe and challenging play environment that promotes relationships and fosters physical growth and development, curiosity, and exploration. The video shows how staff involve children in everyday routines to create rich learning opportunities.

Time with Toddlers: Training for Caregivers.

Produced by Margie Carter and Kidspace Child Care Center. Purchase \$44.95 plus shipping and handling. Available from Redleaf Press, 450 Syndicate, Suite 5, St. Paul, MN 55104-4125; 800-423-8309, fax 800-641-0115, www.redleafpress.org. 22 min.

Here is help for the exasperated caregiver! *Time with Toddlers* is a captivating video that looks at toddler development. Sequences capture typical toddler behavior and recommended caregiver actions with simple explanations of their behavior by Margie Carter. A useful training guide offers suggestions for follow-up discussions and activities. This video is an effective training resource for toddler training programs at centers, universities, and at child-care resource and referral centers.

Infant Toddler Care. (2002-03)

Developed by Arleen Prairie. Purchase \$89.95 each video, \$459 plus shipping and handling. Available from Magna Systems, 500 Coventry Lane, Suite 200, Crystal Lake, IL 60014; 800-203-7060, fax 815-459-4280, www.magnasystemsvideos.com.

In this series of six videos, caregivers are shown in various settings interacting with infants and toddlers and working in various aspects of curriculum. The care and learning shown emphasize that 1) relationships are key for the very young child in care; 2) quality care is established through individualized care; 3) health, safety, cleanliness, and nurturing are emphasized in care; 4) curriculum is developed from knowing the child; and 5) young children can follow their interests and work on their developing skills within various aspects of curriculum from art to problem solving.

Keys to Quality Infant and Toddler Care.

24 min. This video addresses questions parents, caregivers, teachers, and directors have about quality care. Viewers will see the day-to-day care that is tailored to the individual infant, toddler, and 2-year-old and will hear discussions of the essential components of this care. Emphasized as key are relationships, responsiveness, and individualized care among children, parents, and staff.

Investing In Caring Relationships.

24 min. When the infant or toddler

is in child care the child needs a caregiver who provides time, focus, and consistency, shows responsiveness, and who can communicate with the child in many ways. The child invariably thrives with this emotional investment by the caregiver. When parents and caregivers join together in planning for the child, they form a team that will act to the life-long benefit of that child.

Exploring and Learning.

25 min. Learning for the very young child is centered on the moment-to-moment experiences of his day. This video shows how learning begins with adult child interaction. From there the child learns to handle objects on his own in a variety of ways, and arranges objects such as baskets and blocks. Responsiveness and alertness to each child's individuality both

respects and supports that child's unique way of learning.

Child-Centered Curriculum.

23 min. This video follows infant and toddler caregivers and teachers as they plan curriculum in a center-based care environment. Teachers observe each child; then work as a team to develop a curriculum for that child. Curriculum develops from everyday experiences at the center. Teachers show how a child-centered curriculum is meaningful precisely because it is derived from the child.

Sensory and Art.

24 min. All of the child's developing senses are used in understanding his surroundings. In this video teachers and caregivers demonstrate how they plan materials specifically for involving the senses, providing a sense

of security so the very young child can engage in "messy" activities with freedom. They share their amazement at the fascination and long periods of preoccupation with which the young child stays involved in these activities.

Promoting Language and Literacy.

29 min. This video shows caregivers of infants, toddlers, and 2-year-olds as they follow each child in the beginning stages of language and literacy. Caregivers listen and respond to the child's communication from non-verbal expressions to phrases and sentences. Caregivers discuss ways to help children who show language delays and whose language at home is different than English. Caregivers demonstrate sharing books, using pictures and photos, and introduce materials for scribbling and representation.



Learning Through Observation:

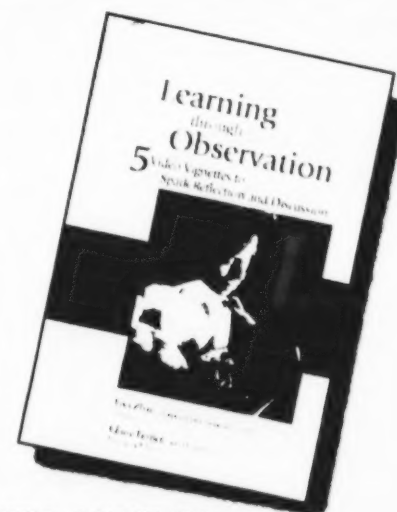
Five Video Vignettes to Spark Reflection and Discussion

Lisa Zbar, Independent Production Fund, Producer
Claire Lerner, ZERO TO THREE, Managing Editor

This video contains five 10-minute video vignettes presented without narration—a format designed to help early childhood professionals learn more about the complexities, challenges, and joys of working with children and families. Viewers observe the following real-life interactions:

1. An occupational therapist's home visit with a child with special needs and his family;
2. Morning drop-off at a child care center
3. Reflection with a supervisor
4. Home visit with a Spanish-speaking family (in Spanish)
5. Early Head Start home visit

Following each vignette, ZERO TO THREE board member Jerree Pawl is joined by staff members Nancy Seibel and Adrienne Sparger in a discussion of what they observed. After each vignette and after the trio's discussions, questions are shown on screen (and are included in the accompanying print guide for photocopying) to stimulate individual or group reflection. Order from (800) 899-4301.



ISBN: #0-943657-62-8
Price: \$64.95
LENGTH: 1:05:00

Infant Mental Health Services: Supporting Competencies/Reducing Risks

(2002) Deborah Weatherston & Betty Tableman (Michigan Association for Infant Mental Health, 13101 Allen Road, Unit 100, Southgate, MI 48195, dkahraman@guidance-center.org). Paperback. \$40.00 plus \$5.00 shipping and handling.

This manual for supervisors and staff of community programs has grown out of Michigan's 25 years of experience in translating Selma Fraiberg's model of "therapy around the kitchen table" into community-based infant mental health services. The manual does not aim to be a complete clinical textbook, but rather is an effort "to systematize the word-of-mouth instructions ordinarily provided by seasoned colleagues to staff of new programs. In addition to an overview of infant mental health principles and infant mental health services, the manual discusses: identification, referral, and enrollment; aspects of home visiting; assessment and service planning; intervention strategies; termination or transfer of services; special populations (for example, parents with developmental disabilities, infants who are abused and neglected); and administrative and organizational issues, including a sample job description for an infant mental health specialist. Special attention is given to the experience of the infant mental health specialist and the value of support from supervisors, colleagues, consultation, and networking.

Appendices provide several assessment instruments, including the Weatherston-Baltman Mother-Infant Attachment Scale, and forms for referrals, informed consent, and quarterly reports. Michigan's Objectives/Problems Checklist for Parent-Infant Services

is included, along with instructions for its use with families and in overall program evaluation.

Unfinished Agenda: Child Care for Low-Income Families Since 1996: Implications for Federal and State Policy

(2002) Jennifer Mezey, Rachel Schumacher, Mark H. Greenberg, Joan Lombardi, & John Hutchins (Center for Law and Social Policy [CLASP], 1015 15th St, NW, Suite 400, Washington, DC 20005, www.clasp.org) Paperback. Free of charge.

The Center for Law and Social Policy (CLASP) worked with non-profit groups in Illinois, Iowa, Maine, Texas, and Washington state to examine the experiences of low-income parents, child care providers, and state child care systems to understand changes in the child care subsidy system since 1996 and their impact on low-income families. This report synthesizes state findings and puts them in a national context; separately published reports on each state are also available.

The receipt of a child care subsidy can improve family economic well-being and give parents greater choice in who cares for their children. But most families eligible for child care subsidies are not receiving them. Limited resources for child care assistance get expressed by states through waiting lists, low eligibility standards, high copayments, prioritization of certain low-income families, limited outreach, and administrative complexity for families seeking or receiving subsidies. These policies, the report argues, have troubling consequences for children and families. The report identifies strategies that the five study states have used to help low-income families get access to a broad range of care and to improve quality. To address supply issues — including care for infants

and toddlers — states have used enhanced rates, bonuses, supports, and training to providers. States have used the required 4% quality set-aside in the CCDF block grant, and other resources, to support collaboration with Head Start, fund child care resource and referral agencies, provide scholarships to child care teachers, offer training, and create links with the health care system. The report offers recommendations for federal policymakers concerning funding quality, administrative barriers, access to a broad array of care, and data collection. Each state report also makes recommendations for policies to address state-specific challenges.

Equal From the Start: Promoting Educational Opportunity for All Preschool Children — Learning from the French Experience (A Report of the French-American Foundation)

(2002) Michelle J. Neuman & Shanny Peer (French-American Foundation, 509 Madison Avenue, Suite 310, New York, NY 10022, www.frenchamerican.org) Paperback. \$10.00 including shipping and handling.

This report is the fourth in the "A Welcome for Every Child" series of publications, which describe French systems of health care and education for very young children and their families. *Equal From the Start* focuses on France's approach to supporting the development of young children in poor and immigrant neighborhoods. The authors identify six key attributes of France's approach:

1. Voluntary, free preschool available for all children.
2. An education policy that spends 10% more per student in disadvantaged areas.
3. Additional resources flowing in a non-stigmatizing, inclusive

manner to "priority education zones" within a universal system that holds all children to the same high standards.

4. Emphasis on two-year-olds, with attention to linguistic, cognitive, social, and physical development, and special programs to help make disadvantaged two-year-olds make the transition from home to school.
5. Integration of children from immigrant backgrounds through immersion in French language and culture, while encouraging the retention of native languages and cultures in the home.
6. Comprehensive social support for children's and families' needs through links between schools and other services, and the use of mediators from local communities.

The authors suggest that the most important lesson from the French experience is that it is possible to provide additional resources and support to disadvantaged children within a high-quality system of universal services (rather than a separate program, like Head Start). They argue that a universal, comprehensive approach is the best way to ensure that children from low-income and immigrant backgrounds receive the quality early learning experiences they need.

Children in Play, Story, and School

(2001) Artin Goncu & Elisa L. Klein, Eds. (Guilford Publications, 72 Spring Street, New York, NY 10012, www.guilford.com) Hardcover. \$48.00.

This collection of 17 essays honors the contributions of Greta G. Fein to the field of developmental psychology and early childhood education in three areas: children's pretend play, storytelling, and the role of child care in children's development and education. Three chapters address issues in infant/toddler child care. Alison Clarke-Stewart, one of three authors of a chapter on "Day

Care and the Strange Situation," recalls the "infant day care wars" of the mid-1980s, ZERO TO THREE's Infant Day Care Summit (which brought together researchers who had been debating the possible harmful affects of child care on children's emotional development), and the ongoing National Institute of Child Health and Human Development (NICHD) Study of Early Child Care. The authors' research lends support to the possibility that children's attachment insecurity that seemed to be linked to child care participation may have been affected by use of the strange situation as the sole method of assessing attachment.

Carolee Howes and Erin Oldham examine the formation of attachment relationships with caregivers — what behavior repertoires children brought to child care, how they approached the task of trusting someone taking care of them, and how long it appeared to take to build a new relationship. Their findings underscored Greta Fein's earlier conclusion that "the quality of interaction provided by caregivers is crucial." Nathan A. Fox and Yair Bar-Haim focus on issues of continuity and discontinuity in attachment organization and representation. Their review of attachment research leads them to conclude that "the process by which individuals develop the capacity to form intimate and healthy relationships with significant others involves many...instabilities and inconsistencies in parental response." They suggest that we need a broader view of the infancy period and less sharply defined notion of the criticality of the first year of life.

Behavior Problems in Preschool Children: Clinical and Developmental Issues (second edition)

(2002) Susan B. Campbell (*The Guilford Publications*, 72 Spring Street, New York NY 10012) Hardcover. \$38.00.

The author, a professor of psy-

chology at the University of Pittsburgh, notes that it is widely accepted that the period between ages 2 and 5 is one of extremely rapid developmental change and that there are wide individual differences in the rates at which such change occurs. She adds that when the first edition of this book was written in 1989, it was generally assumed that early problems would be outgrown. Now, however, it is accepted that a small proportion of children with problems in the preschool period will continue to have significant difficulties later on. The book synthesizes many recent studies on which children are truly at risk and which may be likely to be going through a more temporary problem.

Campbell uses the transactional model of development formulated by Arnold Sameroff and his colleagues as a way of understanding developmental psychology — that is, why development goes awry in some children but not in others who have ostensibly similar histories and experiences. She goes on to address developmental issues, clinical issues, family factors and temperament, sibling and peer relationships, the prevention and treatment of behavior problems in young children, follow-up and outcome studies, and social policy implications of developmental findings. In describing factors influencing referral of young children to mental health clinicians, Campbell reflects on the wide variation in parents' knowledge of normal development and expectations for their children's behavior that she sees in clinical practice. (She recommends education for parenting that includes information about infants' needs for social interaction and close bodily contact, and about individual differences.) Discussing diagnostic issues, Campbell examines DSM-IV, DSM-PC, and DC:0-3 as these systems address young children's disruptive behavior. Reviewing longitudinal studies of toddlers and preschoolers, she notes

that most studies suggest that family discord or disruption, negative and conflict-ridden parent-child relations, and maternal depression or anxiety are associated with both the onset and persistence of problems.

What Kids Need:

Today's Best Ideas for Nurturing, Teaching, and Protecting Young Children (A Carnegie Corporation Initiative: A Decade of Progress in Early Education)

(2002) Rima Shore (Beacon Press, 25 Beacon Street, Boston, MA 02108-2892, www.beacon.org) Hardcover. \$25.00.

In 1994, the Carnegie Corporation's Task Force on Meeting the Needs of Young Children published *Starting Points*, a report that urged the nation to pursue four goals to support the healthy development of infants and toddlers: promoting responsible parenthood; ensuring good health and protection; guaranteeing quality child care choices; and mobilizing communities to support young children and their families. Today, Rima Shore notes, progress toward these goals is substantial but uneven. This volume describes what families need, what infants and toddlers need, what preschoolers need, and a proposed agenda for change. Shore identifies "four realities" to guide policy concerning families with very young children: 1) parents want and need time with their young children, 2) most families need out-of-home care for their infants and toddlers, 3) a comprehensive approach to infant and child care will have to incorporate parental, kin and kin, family home, and center-based care, and 4) providers need to be held to standards designed to protect children's health and safety, and to promote early learning. The agenda for change offered in the book recommends creating and funding an early childhood

infrastructure including public engagement, parent engagement, professional development (through strengthening curricula of institutions that prepare early educators), finance, governance, and accountability systems.

The Dana Guide to Brain Health

(2003) Floyd E. Bloom, M.D., M. Flint Beal, M.D., & David J. Kupfer, M.D., Eds. (The Free Press, 1230 Avenue of the Americas, New York, NY 10020) Hardcover. \$45.00.

This 733-page volume is designed as a reference to the latest understandings of brain diseases and a source of information to help families participate in the care of a family member with a brain disease. The Guide offers an illustrated "brain primer," a discussion of brain research, a description of the brain throughout the lifespan, an analysis of brain functions, and information about conditions of the brain and nervous system. The chapter on prenatal brain development offers, along with information on the developing brain itself, nutritional advice for mothers, an explanation of prenatal tests, and the slim evidence for meaningful differences between girls' and boys' brains. In the chapter on brain development in childhood, the editors note the importance of establishing a strong, nurturing relationship between parents and their baby, while admitting that researchers may never be able to say for sure how much supportive care is necessary to rear an emotionally well-balanced child. This chapter also notes that one of the biggest contributions of brain imaging studies has been to show that the most difficult mental disorders are connected to abnormal chemistry in the brain, not to anything that parents or children have done.

A chapter on conditions that appear in childhood discusses dyslexia, attention deficit/hyperactivity disorder, mental retardation, cerebral

palsy, autism, metabolic diseases, neurofibromatosis, hydrocephalus, spina bifida, and tumors of childhood. For each condition, the authors describe manifestations, mechanisms and causal factors, treatment, and teaching. Appendices include a glossary, a description of drugs used to treat the brain and nervous system, and resource groups.

Also of Interest:

Calming Your Fussy Baby: The Brazelton Way (2003), by T. Berry Brazelton, MD, and Joshua D. Sparrow, MD (Perseus Publishing, 11 Cambridge Center, Cambridge, MA 02142, <http://www.perseuspublishing.com>) \$9.95. ZERO TO THREE board member T. Berry Brazelton and coauthor Joshua D. Sparrow provide step-by-step advice for interpreting and calming a baby's cries. The authors describe the ways a baby communicates at different ages, including different types of cries, what the cries mean, and proven methods for soothing the baby.

Sleep: The Brazelton Way (2003), by T. Berry Brazelton, MD, and Joshua D. Sparrow, MD (Perseus Publishing, 11 Cambridge Center, Cambridge, MA 02142, <http://www.perseuspublishing.com>) \$9.95. The authors outline typical sleep patterns for infants and children up to age 5 and describe solutions for a range of sleep problems including bedtime struggles, bedwetting, early morning waking, nightmares, sleep apnea, and night "terrors."

Discipline: The Brazelton Way (2003), by T. Berry Brazelton, MD, and Joshua D. Sparrow, MD (Perseus Publishing, 11 Cambridge Center, Cambridge, MA 02142, <http://www.perseuspublishing.com>) \$9.95. The authors remind parents that discipline is teaching, not punishment, and that the long-term goal is to instill self-discipline in the child. This book explains appropriate methods of discipline for chil-

dren as they age and evaluates common methods of discipline.

More Infant and Toddler Experiences (2001) by Fran Hast and Ann Hollyfield (Redleaf Press, 450 N. Syndicate, Suite 5, St. Paul, MN 55104-4125, www.redleafpress.org) The authors, both teachers at an infant-toddler center, describe over 100 activities that will be fun and rewarding for the children while also helping the caregivers to improve their skills in teaching and relating to children.

The Affect-Based Language Curriculum (ABLC): An Intensive Program for Families, Therapists, and

Teachers (2002) by Stanley I. Greenspan, MD, and Diane Lewis, MA, CCC/SLP (Interdisciplinary Council on Developmental and Learning Disorders, 4938 Hampden Lane, Suite 800, Bethesda, MD 20814, www.idcl.com) The purpose of the Affect-Based Language Curriculum is to provide families, therapists, and teachers a systematic, intensive program based on both new insights and traditional knowledge of the development of communication and language. With this program, family members and professionals work as a team to help children master both the building blocks and more advanced components of language.

advocates and others to discuss how research, practice, and policy can best prepare young children and families for later school success. Joan Lombardi facilitates the Exchange.

Set for Success comprises 2 papers that describe scientific research findings on the importance of social and emotional development for school readiness. The report recommends a number of strategies for building on this knowledge base:

- Think of social-emotional development and academic achievement not as separate priorities but as representing the continuum of development that is needed for children to grow up healthy and succeed in school.
- Disseminate knowledge about the links among social, emotional, and cognitive development to parents, teachers, caregivers and policymakers.
- Provide training and education to promote social-emotional development and the importance of strong relationships between young children and their families, their teachers, and their caregivers.
- Offer mental health services to children and families in familiar, trusted, nonthreatening community-based settings such as child care, schools, and community centers.
- Give priority to and invest in policies that enhance the social, emotional, and cognitive well-being of infants, toddlers, preschoolers, and their families in order to help children entering school ready to learn and succeed.

Other papers from the Kauffman Early Education Exchange include:

The View From Research

The Roots of Social-Emotional Development, by Ross Thompson, Ph.D.

The Connections between Social-Emotional Development and Early Literacy, by Linda Espinosa, Ph.D. and

ON-LINE RESOURCES

A "Noble Bet" in Early Care and Education: Lessons From One Community's Experience

(2002) Brian P. Gill, Jacob W. Dembosky, and Jonathan P. Caulkins (Prepared for the Heinz Endowments, RAND Education, RAND)

www.rand.org. Also available in paperback for \$20 from RAND, (310) 451-7002 or order@rand.org.

RAND, a nonprofit research institution, was commissioned by the Heinz Endowments to evaluate the vision, organization, administration, and operation of the Early Childhood Initiative (ECI). ECI worked from 1996-2000 under the auspices of the United Way of Allegheny County to improve early care and education (ECE) for low-income children from birth through age 5 in Pittsburgh, Pennsylvania, and surrounding communities. Although RAND evaluators found that ECI led to the establishment of new, high-quality ECE services in several communities, it failed to achieve many of its major goals: providing high-quality ECE services; serving children on a large scale (7,600 children in 80 neighborhoods within 5 years); using a

community-driven approach; and achieving sustainability through a commitment of state funding. ECI's success was undermined, RAND evaluators suggest, because the project lacked a clear sense of market realities, a well-designed theory of action, an effective strategy for inducing a commitment of public funding, and a coherent organizational structure. The report includes information on four initiatives that offer alternative approaches to scaling up high-quality ECE services. Each of these has a narrower focus than ECI on a more limited number of goals, and most focus on existing providers.

Set for Success: Building a Strong Foundation for School Readiness Based on the Social-Emotional Development of Young Children

(2003) Lisa Klein (The Kauffman Early Education Exchange)

www.emfk.org/

This report is part of the Kauffman Early Education Exchange conference series, established in 2001 provide a venue for policymakers, practitioners, early childhood

Rebecca McCathren, Ph.D.

Culture and Ethnicity in Social, Emotional, and Academic Development, by Oscar Barbarin, Ph.D.

Implications for Practice Promising Social-Emotional Development in Young Children: The Role of Mental Health Consultants in Early Childhood Settings, by Paul Donahue, Ph.D.

Promoting Social-Emotional Development in Young Children: Promising Approaches at the National, State, and Community Levels, by Roxane Kaufmann, Ph.D. and Deborah Perry, Ph.D.

Implications for Policy

Promoting Social-Emotional Readiness for School: Toward a Policy Agenda, by Jane Knitzer, Ph.D.

Promoting the Well-Being of Infants, Toddlers, and Their Families: Innovative Community and State Strategies

(2002) National Center for Children in Poverty (NCCP)

www.nccp.org

In 2001, the National Center for Children in Poverty (NCCP) sponsored a national call for nominations of comprehensive initiatives to support infants, toddlers, and their families. Information presented throughout this website draws on the experiences of 25 selected initiatives across the country to provide a menu of strategies that states and communities can use to promote more targeted and effective policy and practice attention to infants and toddlers.

The website includes descriptions of five overarching STRATEGIES employed by the initiatives—building infrastructure, using federal programs as platforms, enhancing family support, developing new approaches to training and technical assistance, and supporting vulnerable populations. Short summaries and longer profiles highlight particularly noteworthy aspects of the selected initiative. Advocates and policy makers are offered links to promote awareness, policies, and programs targeting

the needs of infants, toddlers, and their families.

Many of the selected 25 programs are likely to be familiar to *Zero to Three* readers, including the Kansas Early Head Start Expansion (featured in this issue), the Program for Infant-Toddler Caregivers, Smart Start, the Infant and Young Children's Initiative of the Miami-Dade County Juvenile Court, and the Preschool Witness to Violence Program/Child Trauma Research Project and San Francisco General Hospital.

A Benefit-Cost Analysis of the Abecedarian Early Childhood Intervention

(2003) Leonard Masse and W. Steven Barnett (National Institute of Early Education Research [NIEER])

<http://nieer.org/docs/>

This is the report of new research on the Abecedarian Early Childhood Intervention Program in North Carolina. Earlier studies have shown that children enrolled in the program fared significantly better in school and had better prospects as adults than children in a control group. This new study, conducted by researchers at the National Institute of Early Education Research (NIEER), was designed to determine whether the program's benefits to society were worth the costs. Researchers concluded that taxpayers received a four-to-one return on their investment, in addition to significant social dividends and including better school success. Participating children and their mothers had significantly higher lifetime earnings than those in the control group.

Major findings of the benefit-cost analysis include:

- The children in high-quality programs are projected to make roughly \$143,000 more over their lifetimes than those who didn't take part in the program.
- Mothers of children who were enrolled can also expect greater earnings—about \$133,000 more over their lifetimes.

- School districts can expect to save more than \$11,000 per child because participants are less likely to require special or remedial education.
- Results suggested a possible impact on smoking. Participants were less likely to smoke (39% vs. 55% in the control group), resulting in health benefits and longer lives, for a total benefit of \$164,000 per person.

The Abecedarian Project began in the 1970s, with 57 infants from families with low incomes in Chapel Hill, North Carolina, randomly assigned to a high quality child care setting. Another 54 were in a control group that did not receive the same intervention and high-quality education, although some of the children in the control group also attended child care centers. The children in the high-quality child care setting attended from infancy through age 5, at an average annual cost of \$13,000 (2002 dollars). Educational activities addressing each child's needs were incorporated into their day.

THE SALLY PROVENCE AWARD FOR EXCELLENCE

* Recognizes, in alternate years, individuals and service programs whose work with infants, toddlers, families, and communities demonstrates the qualities that Dr. Provence considered essential to effective practice.

* Honors Sally Provence, M.D., a pioneer in the infant-family field and a founding member and president of ZERO TO THREE. As a pediatrician and mental health clinician at the Yale Child Study Center, she called attention to qualities in both individuals and programs that are likely to lead to success in supporting the development of very young children:

- an abiding curiosity about the meaning of behavior in very young children and their families;
- a sturdy conceptual framework for understanding developmental issues and problems in children and parents that also serves as the foundation for services;
- continuity and individualization

of respectful, trustworthy care; and

- training and ongoing support for all professionals who touch the lives of babies, toddlers, and families.

Eligibility

The 2003 award will be made to an individual.

Nomination Process

Individuals can nominate themselves or be nominated by others. In the latter case, the nominator will determine the individual's willingness to be considered, provide contact information, and request that ZERO TO THREE send the individual an application.

Selection Process

Individuals wishing to be considered for the award will complete an application that focuses on the way in which the four professional characteristics, listed above, are brought to bear on services to children and families.

The application, due August 1, 2003, includes questions for both the individual, other professionals with whom the nominee works, and parents served.

An Awards Committee will review all applications and notify applicants by September 15.

Recognition

The award will be presented at the December 6, 2003, awards luncheon at ZERO TO THREE's National Training Institute in New Orleans, LA. Travel, hotel, and registration costs for the recipient will be complimentary. The recipient will also be featured in the *Zero To Three* Journal and on the organization's Website.

For More Information

For an application, please e-mail Bill McCall, Program Associate, at bmccall@zerotorthree.org, or call him at (202) 638-1144, ext. 665.

CONFERENCE CALL

The 16th Annual Bank Street College Infancy Institute will be held on **June 17-19** at Bank Street College, in New York City. More than 30 small-group workshops and 3 full-day seminars will address, among other topics, brain development, supervision of child care staff, sensory integration, and caregiver-parent relations. Visits to exemplary infant-toddler programs are also planned. Kathy Hirsh-Pasek will deliver the keynote address, "Breaking the Language Barrier: How Children Develop Their First Language." Some scholarships are available. For more information contact Carla Poole or Merrill Lee Fuchs at: 212-875-4728 (phone); 212-875-4753 (fax); InfancyInstitute@bankstreet.edu.

Dr. Alice Honig's 27th annual Quality Infant/Toddler Caregiving Workshop will be held **June 16-20**

at Syracuse University. In addition to Dr. Honig, faculty will include Thomas Fiscoe, Abraham Sagi, Susan Snyder, Nan Songer, Anne Sveen, and Mary Anne Theiss. Topics will include the growth of intelligence and emotion, separation and attachment issues in infant care, becoming a better observer of babies, infant sexuality, and assessing infants. The institute will include observations and hands-on interactions with infants, and viewing of infant-toddler videos and films. For information use e-mail (PartTime@uc.syr.edu) or call 24 hours a day: 315-443-YesU (9378).

The **Call for Presentations** is now available for "Promoting Positive Development in Young Children: Designing Strategies That Work," Head Start's 7th National Research Conference, presented by the Admin-

istration on Children, Youth and Families, U.S. Department of Health and Human Services, in collaboration with Xtria, LLC; Columbia University's Mailman School of Public Health, and Society for Research in Child Development. The Conference will be held **June 28-July 1, 2004** in Washington, DC. The Call is available at www.headstartresearchconf.net. Proposals are due no later than **June 27, 2003**. Inquiries about submission content may be directed to Dr. Faith Lamb-Parker; Columbia University; Mailman School of Public Health; flp1@columbia.edu; 212-305-4154; Fax: 212-305-2015. Questions regarding the submission process or opportunities to become a reviewer of the submissions may be directed to Bethany Chirico; Xtria, LLC; hsrc@xtria.com; 703-821-3090 ext. 261; Fax: 703-821-3989.

ANNOUNCING THE 2003 CLASS OF FELLOWS

ZERO TO THREE's Leaders for the 21st Century program, supported by the Robert Wood Johnson Foundation, the Harris Foundation, and the California Endowment is pleased to announce the selection of the 2003 class of Fellows. Leaders for the 21st Century was established in 1999 with the goal of identifying current and future leaders in the multidisciplinary infant-family field and helping them expand their knowledge and enhance their ability to make a difference in the lives of infants, toddlers and their families.

Eleven Solnit Fellows (individuals in the early stages of their careers) and 11 Harris Mid-Career Fellows (experienced professionals with an established record of leadership and achievement) were selected from a highly competitive pool of finalists. The new Fellows represent 11 different disciplines including psychiatry, psychology, psychoanalysis, social work, pediatrics, law, policy, public health, early childhood education and linguistics. The 19 women and three men come from 11 states and Australia, and range in age from 30s to 50s. Fellows will participate in a variety of activities designed to further their career goals, increase their leadership skills, expand their knowledge and perspective, and enlarge their collegial circles. Each Fellow will also work on a self-directed project with ongoing guidance and support from ZERO TO THREE Board members, staff, Graduate Fellows, and other experts.

For more information on the Leaders for the 21st Century program please visit our website at www.zerotothree.org.

Solnit Fellows:

Kelley Y. Abrams, PhD
(Research Psychologist, Through the Looking Glass, Berkeley, CA)

Elizabeth B. Caronna, MD
(Developmental & Behavioral Pediatrician, Boston Medical Center)

Mari T. Fernandez, PhD (Associate Director/Coordinator of Clinical and Outreach Programs, Center for Research on Children's Development and Learning, College of Education, University of South Florida, Tampa Florida)

Jenifer Goldman-Fraser, PhD
(Adjunct Assistant Professor, Boston University School of Public Health)

Victoria Hendrick, MD (Psychiatrist, Los Angeles County Infant Mental Health Program)

Debra Jervay-Pendergrass, PhD
(Speech-Language Pathologist, Montgomery County Public Schools, Rockville, MD)

Vonda K. Jump, PhD (Research Associate, Early Intervention Research Institute, Utah State University)

Katherine R. Locker, JD (Attorney, The Legal Aid Society, Juvenile Rights Division, New York, NY)

Sharon M. Powell, BSN, PHN, RN (School District Nurse, El Tejon Unified School District, Lebec, CA)

Julia C. Stone, MD (Infant, Child & Family Psychiatrist, Princess Margaret Hospital for Children, Perth, Australia)

Ayelet Talmi, PhD (Research Fellow, Developmental Psychobiology Research Group, University of Colorado, Health Sciences Center)

Harris Mid-Career Fellows

Therese M. Ahlers, MA (Director, Wisconsin Initiative for Infant Mental Health)

Sheryl Dicker, JD (Executive Director, New York State Permanent Judicial Commission on Justice for Children)

Paula J. Erdelyi, MSW (Nurturing Partners, Louisville, KY)

Toni V. Heineman, DMP (Associate Clinical Professor, Departments of Psychiatry and Pediatrics, University of California, San Francisco)

Lester Langer, JD (Associate Administrative Judge, Circuit Court Juvenile Division, 11th Judicial Circuit, Miami, FL)

Connie M. Lillas, PhD, MFT, RN (Psychoanalyst, Director of Infant Mental Health Training for The Early Childhood Center Foundation, a program affiliated with the Department of Psychiatry and Mental Health, at Cedars-Sinai Medical Center, Los Angeles)

Barbara S. Marcus, MA (CEO, Parents in a Pinch, Inc., Brookline, MA)

Kofi Marfo, PhD (Director, Center for Research on Children's Development and Learning, University of South Florida) Building University-Community Partnerships in Support of State School Readiness Initiatives

Alan L. Mendelsohn, MD
(Assistant Professor of Pediatrics, New York University School of Medicine and Bellevue Hospital Center)

Barbara A. Thompson, MS
(Senior Program Analyst, Office of the Deputy Under Secretary of Defense, Military Community and Family Policy, Washington, DC)

Zohreh Zarnegar, PhD (Clinical Psychologist, Los Angeles County Department of Mental Health)

UPCOMING ISSUES

May 2003—Caregiver Goals and Societal Expectations is being co-guest-edited by members of the Four-College Consortium – Virginia Casper, Bank Street; Fran Stott, Erikson Institute; Renatta Cooper, Pacific Oaks; and Cathy Finn, Wheelock College. Contributors explore cross-cultural tensions at multiple levels of practice and policy and describe strategies for discovering common ground.

July 2003 – Evaluating Programs That Serve Infants and Families: Graduates of the ZERO TO THREE Leadership Development Initiative Class of 2001-2 address the theoretical, methodological, logistical, and political challenges of evaluating infant/family programs. Co-guest-editors Virginia Buysse and Lisa Boyce and their colleagues repre-

sent the worlds of child care, early intervention, infant mental health, and comprehensive, publicly funded initiatives. They will analyze, among other issues, new emphases on accountability and evidence-based practice, using multiple case examples to illustrate their discussion.

September 2003 – ZERO TO THREE and the Infant/Family Field This issue will mark the 25th anniversary of ZERO TO THREE with reviews, by ZERO TO THREE Board members and colleagues who have entered the infant/family field more recently, of major trends in theory, research and practice. Contributors will examine infant/toddler child care, training and practice in infant mental health and infant/family practice in general, emerging models of early development, parent advocacy, and trends in public policy.

THE EDITORIAL MISSION OF THE ZERO TO THREE BULLETIN

To provide a forum for thoughtful discussion of important research, practice, professional development, and policy issues in the multidisciplinary infant, toddler, and family field.

THE MISSION OF ZERO TO THREE: NATIONAL CENTER FOR INFANTS, TODDLERS, AND FAMILIES

ZERO TO THREE is a national nonprofit whose mission is to promote the healthy social, emotional, and intellectual development of our nation's infants and toddlers by supporting and strengthening families, communities, and those who work on their behalf.

www.zerotothree.org

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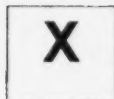


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